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ABSTRACT

This text was written as an outgrowth of 6 years' work with children aged 3-5 in the Child Development Center at Western Oregon State College, Monmouth, Oregon. The children attending this program included typically developing children as well as children with disabilities. A primary purpose of this book is to share the experiences and learnings with others who are also serving preschoolers with disabilities in the belief that the adoption of a proven, systematic approach to integrated service delivery will result in high quality services to all children, including those with disabilities. The text describes a model program called the Teaching Research Integrated Preschool (TRIP) model. The philosophy of service embodied in the model is reflected in a fully integrated community program where all children participate in the same routines and activities. It is based on a blend of the behaviorist, cognitive developmental, and social learning theories, and contains some aspects of the maturationist perspective as well. The first of nine chapters discussing model components provides an overview of integrated preschool services. Topics of the remaining chapters are: (2) assessment and individual family service plan development; (3) activity-based instruction; (4) individualizing instruction; (5) monitoring the child's progress; (6) enhancing social interaction; (7) training and support for staff; (8) parent involvement; and (9) the role of related service providers. Appendices include guidelines for programs serving preschool children with handicaps in Oregon in Head Start, preschool, day care, or kindergarten settings; an overview of the evaluation and programming system; an environmental survey form; and copies of blank forms. References accompany each chapter. (JDD)

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SUPPORTING CHILDREN WITH DISABILITIES IN COMMUNITY PROGRAMS

SUPPORTING CHILDREN WITH DISABILITIES IN COMMUNITY PROGRAMS

The Teaching Research Integrated Preschool

Joyce Peters and the staff of the
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PREFACE

This book was written as an outgrowth of our work during the past six years with children ages 3-5 in the Child Development Center at Western Oregon State College in Monmouth, Oregon. The children attending this preschool program include those who are typically developing as well as those who experience disabilities. Although based on our experiences in a college setting, we believe that the strategies and procedures will be useful with children in other locations as well. The strategies presented here have been validated by numerous early childhood and early childhood/special education teachers and administrators who have participated in inservice training activities offered through our national early childhood outreach project.

A primary purpose of this text is to share our experiences and learnings with others who are also serving preschoolers with disabilities and their families. We believe that the adoption of a proven and systematic approach to integrated service delivery will result in high quality services to **all** children, including those with disabilities. We are constantly encouraged by the benefits we see occurring for young children in programs that are built on a sound base of developmentally appropriate practice supplemented with proven practices from early intervention.

The second purpose of this text is to provide a detailed description of the model program that has evolved from our work. This book covers each component of The TEACHING RESEARCH INTEGRATED PRESCHOOL (TRIP) model and links them to the underlying, supporting practice. Our hope is that this book will stimulate professionals in all facets of early childhood education to adopt a model of service that commits to incorporating the best that both early childhood and special education have to offer. We believe this approach will result in life-long benefits to children with disabilities.

Chapter One

OVERVIEW OF INTEGRATED PRESCHOOL SERVICES

Torry Piazza Templeman, Constance Lehman, Lisa Carlson

The idea that children who have special needs might be educated with their peers in neighborhood schools, rather than in segregated classrooms or institutional schools, is not new. As early as the 1940s, human service and education experts raised the issue of integration versus segregation. In an address to the 1946 Convention of the International Council of Exceptional Children, one speaker said, "There should be as little segregation as possible because the child should not be deprived of the socializing influence of the regular school if it is possible to help him in regular groups in regular schools" (Biklen, 1981). During the following decade, the civil rights movement for people with disabilities gained momentum in the United States and Europe.

The term "normalization" was coined by Bienk-Mikkelson in Denmark in 1959. The Principle of Normalization purports that people with disabilities, no matter what age or what type of disability, have the right to live as normal a life as possible. From the 1950s to the present, those who have advocated integration of people with disabilities have based their opinions on this principle.

The movement to ensure that people with disabilities be in the mainstream of society gained momentum in the 1960s in the United States. For example, in 1962, more than a decade before the phrase "least restrictive environment" was defined, Maynard Reynolds, a well-known special educator, wrote that the special placement of a child . . . should be "no more special than necessary" (Biklen, 1981). Throughout the 1960s people continued to insist that individuals with disabilities be included in the society, rather than excluded. The widespread practice of exclusion which existed prior to the 1970s often meant the confinement of children and adults with disabilities to large institutions. The other "option" was for parents to care for their children at home for as many years as they were able, with little or no support from the community. These children were excluded from public school and denied meaningful employment as adults. As the result of the persistent actions of parents, legislation was passed in 1975 which dramatically changed our society's treatment of children with disabilities.

Legislation Regarding Integration

The passage of P.L. 94-142, The Education of All Handicapped Children Act, was a legislative breakthrough resulting from parents' commitment to establish services for their children. This 1975 law mandates states to develop methods to provide a free public education in the least restrictive environment (public school settings) for all children with handicaps no matter how severe the condition. Since the enactment of P.L. 94-142, the concept of special classrooms within the public schools is no longer considered viable. Professionals face the challenges of interpreting the term "least restrictive environment" in light of legislative mandate. In many states there continues to be opposition to moving children out of specialized schools. In other cases, some want to wait until research can prove where and how children with disabilities learn best and what skills are the most important for them to learn. Regardless of these unresolved issues, the commitment of parent and professional advocates to provide opportunities for children with disabilities to be with their peers from infancy onward created the passage of P.L. 99-457 in October of 1986.

P.L. 99-457 amends P.L. 94-142 to mandate preschool educational services for children 3 through 5 years old. It also establishes incentives for states to develop comprehensive services for children, birth to 3 years, and their families. This law demonstrates a national commitment to support and educate young children with special needs in the least restrictive environment. In less than 20 years, children with disabilities have moved from a position of institutionalization and segregation from families, communities, and friends to a position of receiving integrated educational opportunities. They are also being recognized for their contributions to their communities and society. Society's commitment to this shift in position provides initial impetus to establish high quality integration of young children with special needs into their community's early childhood programs.

Today's integration practices have developed as a result of work done during the 1960s. The social consciousness of the 1990s as well as the work of professionals like Hunt (1964) and Bloom (1964) first led to early childhood programs to help the economically disadvantaged. Prior to this time, the care of infants and young children was primarily custodial care, with limited emphasis on educational needs such as cognitive and social skill development. In 1965, Head Start was established in an effort to bridge the gap between the "haves" and the "have nots." Not only has Head Start provided an integrated setting for many children with a wide range of disabilities since the mid 1960s, but also, as a result of the health screenings that are a requirement for all children enrolled in the program, has identified children with special needs.

Following Head Start's lead, the Bureau of Education for the Handicapped (BEH) established the Early Childhood Assistance Program in 1968. The BEH provided money to develop model preschool programs for children with disabilities. The Handicapped Children's Early Education Program (HCEEP) was established to stimulate and support innovative models of service for preschool children with disabilities. Throughout the 1970s and 1980s HCEEP projects were the major source of model development and dissemination of the findings for schools and other organizations throughout the country. It was not until the past decade, however, that the true integration of preschool children with handicaps became the focus of projects such as the Teaching Research Integrated Preschool (TRIP).

Review of Learning Theory

In order to better understand the theory which underlies the TRIP model, a brief review of learning theory and its application to early childhood education, special education, and integrated education approaches is helpful. Historically, learning theory generally encompasses three broad categories: contemporary behaviorism (Pavlov, Thorndike, Watson, Skinner), cognitive developmental theory (Piaget, Werner, Kolhberg), and social learning theory (Bandura).

The behaviorist would say that an individual's learning occurs by the pairing of stimuli through which conditioned responses are acquired (classical) or by an individual operating on his or her environment and receiving consequences which shape the future occurrence of that behavior (operant). From this, evolved the teacher-centered, teacher-directed classroom structure. Traditional special education programming and curricula are based on this branch of learning theory. A strength of the behaviorist approach is the ability to target the behavior desired and to clarify the steps necessary to teach that behavior. A major disadvantage lies in the lack of opportunity for the child to generalize the behavior being learned, mainly due to the limited situation in which it is practiced.

Cognitive developmental theories, like operant conditioning, emphasize an individual's interaction with the environment. In the cognitive developmental models, the emphasis shifts away from the pairing of responses and consequences and instead focuses on acquisition of knowledge by assimilation and accommodation through the predictable and invariant stages of cognitive development.

Cognitive developmentalists would say that the individual is "an action-oriented, searching, seeking, continually adapting organism" (Stevens & King, 1976, p. 32). Piaget believed that children learn through spontaneous play with people around them and with their environment. Many early childhood training programs, as well as preschool curricula for typical children, are based on Piaget's theory of learning. The programs are child centered and are designed for learning through exploration and discovery. Learning centers are designed to stimulate curiosity and experimentation with the environment (Stevens & King, 1976).

The social learning theorists also view learning as active and involving interaction with other individuals in the environment. Albert Bandura (1971) believed that children learn through observing and imitating the behaviors and actions of other people in their environment. He also suggested that the willingness of children to imitate others is affected by a range of motivational and reinforcement factors. Bandura observed that children tend to imitate the behaviors of others who are perceived to be more competent or are in high status positions, and that children will imitate behaviors that result in positive outcomes. He also found that children did not imitate behaviors that resulted in punishment. His findings present educators with a strong argument in support of integrated services. Bricker (1989) indicates that, in order for children with handicaps to acquire new behaviors through observation of other children, the opportunity for watching and imitating the more complex behaviors of their peers must be available.

The maturationist view of Arnold Gesell also plays a key role in the development of effective integrated early childhood programs. Gesell suggests that the individual is born with innate capabilities and that these abilities show up when the child is "ready." This approach is not acceptable to many special educators. Although the classroom environment is organized and positive, the concept of recognizing the signs that a child is ready to learn to read, for example, would mean that many children with special needs would receive little individualized instruction. On the other hand, the organization of curricula into units or central themes, such as family, community helpers, seasons, and so on, can provide a structure conducive to incorporating children with special needs. Pioneers in the field of early intervention with young children in integrated settings have developed "blended" curricula approaches.

The Brickers developed a learning model in the mid 1970s which Anastasiow (1978) calls the Cognitive Learning Model. In this model, operant procedures are followed for remediation while a cognitive developmental approach determines a child's developmental level to facilitate the planning of intervention strategies (Thurman & Widerstrom, 1990). The successful integration of young children with special needs into community preschools begins by identifying the individual's learning theory orientation. The acknowledgement that there is no one solution that will meet the needs of all children, be they typical or exceptional, is the common ground which early childhood educators and special educators have discovered during recent years. In light of this, the Teaching Research Integrated Preschool (TRIP) model is based on a blend of the behaviorist, cognitive developmental, and social learning theories, and contains some aspects of the maturationist perspective as well.

The goals of integrating young children with special needs into the typical preschool are both social and educational. The social goals of fostering friendships and acceptance can best be reached by providing a warm, positive environment. A child-directed approach provides the opportunity for children to initiate interactions and exploration of the environment in natural ways. The teacher can plan and implement strategies to facilitate these interactions, based upon the individual needs of the child. Individualized educational goals can be taught in a variety of ways in the integrated preschool when the underlying philosophy is a blend of traditional early childhood and special education learning theories.

Within the integrated community preschool, there are abundant opportunities to "practice" skills in a variety of situations with a variety of people. Children with special needs are challenged to think and decide for themselves, while having the ongoing support of the other children as well as the staff. In the work surrounding preschool integration and mainstreaming, peers have long been recognized as significant players in the potential success of integration.

Although debate continues regarding how, when, or if to structure peer interactions within the integrated settings, there is little evidence in the research to support that the "proximity model" (i.e., simply having children with special needs and typical children together in the same classroom) has a positive effect on the developmental progress of the children with special needs (Guralnick, 1975). There is, however, research indicating that preschool children with special needs do benefit through the social interactions available in the integrated preschool setting. Devoney, Guralnick, and Rubin (1974) found that the integrated setting provided "advanced models during play" which, in turn, afforded the special needs children the opportunity to observe and participate in more complex communication.

Another strategy that is used in the integrated setting is the "cooperative model." In this model tasks are given in which children with special needs and their peers must interact in positive ways in order to reach mutual goals. This model comes from the "cooperative learning" approach developed by Johnson and Johnson in 1975.

A more teacher-directed strategy of peer interaction is the "systematic imitation model." This model is a product of Apolloni and Cooke's Peer Imitation Training (1978). Classroom staff systematically prompt nonhandicapped peers to behave in specific ways and to reinforce the children with special needs when they imitate appropriate behavior. The idea of peers becoming responsible for the social "training" of children with special needs can be viewed as both an advantage and a disadvantage. Some advantages are that the children with special needs receive an abundance of specific opportunities to learn and be reinforced, and progress can be defined and measured. Major disadvantages are certain unnatural interactions created as well as the tendency to reinforce the differences between those children with special needs and those without.

Still more structured and defined is the "confederate model" of peer interaction. The confederate model, as described by Strain, Kerr, and Ragland (1981), is one in which peers are trained by teachers to perform specific tasks. The peer tutor approach is a good example of this model in practice. However, once again, children with special needs are singled out by peers as different from them. The peers in this model assume teacher roles to some extent. An advantage to this approach is that children with special needs are included in specific activities and interact with their peers. Secondly, direct instruction can occur more frequently and can seem more "normal" than one-to-one instruction with adults.

Just as the successful integrated or mainstreamed preschool setting thoughtfully blends several learning theories in order to provide the dynamic atmosphere necessary to maximize social and cognitive development, strategies for peer interactions must also be carefully conceived and planned. If a choice is made to formalize peer interactions in integrated early childhood education programs, it is crucial to remember the basic concept of "normalization."

The TRIP model has chosen to take an informal approach to peer involvement in its classrooms. Through observation over time, Teaching Research has found that when typical children can respond naturally to those with special needs, imitation of behavior can occur. This draws upon the strengths of the children with special needs to problem solve, ask for help, and offer help.

The preceding section has reviewed theories which have supported the work of pioneers in the field of early childhood special education. The historical theories have contributed to an overall approach that ensures that children both with and without special needs have maximum opportunities for social and cognitive development. This dynamic approach to educating all young children offers opportunities to continue to learn what works and what doesn't; educators can thereby adjust and shift programs as needed.

History of the Teaching Research Integrated Preschool Model

During the 1970s, Teaching Research became known for its Data-Based Classroom Model (DBCM) which served young children with disabilities. The DBCM challenged the notion that, for best service, children with disabilities needed to be grouped according to their disabilities. A model system was developed which incorporated a number of key elements: use of volunteers to maximize instruction time, use of related service personnel who work in a consultation role with the teacher; structuring specific roles for teachers, aides, and volunteers; and use of data to make daily educational decisions for students. Many of these practices have withstood tests of effectiveness and replicability and remain valid today. However, many others have not. "Pull out" types of instruction or self-contained classrooms for children with disabilities (part of the old Data-Based Classroom Model) currently are not seen as best practice. The TRIP model incorporates the valid practices with contemporary practice prevalent in the fields of early childhood and special education today. The goal of the model is to provide high quality service for young children with disabilities within community preschool and child care settings. Adapting valid practices of special education to fit into the context of service within community programs is one of the challenges this model is striving to meet. Assessment, program development and planning, as well as monitoring the progress of children within these settings, require change in many elements of a "traditional" self-contained model. The TRIP model has addressed many of these changes and will continue to be developed and refined in the 1990s.

A unique feature of the TRIP model has been the development of one of the first successful, nationwide satellite training networks. Through this network, sites have replicated, with high quality, the components of the model and have developed the capability to train others. This increased capacity to interact with other professionals and test practices on a national basis has facilitated the continual development and refinement of the model at a pace that would have taken years to do at the parent site alone.

Through Office of Educational Research and Improvement, educational models are put to a test of efficacy and replicability as judged by a panel of educational researchers. Those that are judged exemplary are awarded a national validation. The Teaching Research DBCM, the origin of the TRIP model, received such validation in 1978 and again in 1986. This validation assures educators that the model's practices have been proven effective and the quality and effects demonstrated at the parent site were able to be replicated at other sites. The model described here thus contains a level of validity through research and implementation that far exceeds that found in many other descriptions of "best practices."

Foundations For The TRIP Model

The philosophy of integration that the TRIP model embodies is clearly stated in its title. The text that follows will describe a way to provide services to young children with special needs that takes place within the context of existing community preschool/child care programs. That is, young children with special needs will have their care and educational needs met in the same setting as any other young child in the community. This simple, clear statement sets in motion a complex set of discussions, needs, expectations, and outcomes for the professional and family members involved. Many of these complexities, however, are tied to changes in practice, philosophy, and attitude on the part of the adults. The philosophy of service embodied in this model is reflected in a fully integrated community program where all children participate in the same routines and activities. All children served together in this spirit comprise the essence of community--giving, taking, sharing, fighting, loving, and hating as all young children do.

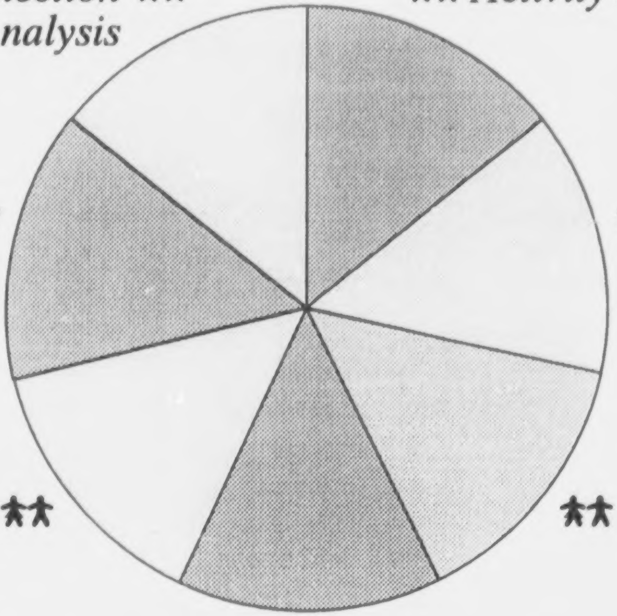
As a program that engages in a broad scope of work in the field of early childhood special education, Teaching Research has a set of program values that guide development and implementation of the early childhood service delivery, policy, research, and evaluation activities. These values have been shaped into the components that embody the TRIP model as shown in Figure 1-1. Research in the field of early intervention has widely supported these components, which include integration, activity-based instruction, environmentally referenced assessment, individualized programming, family involvement, designated staff roles, and data collection and analysis. A further description of each of the components appears in Table 1-1.

Research And Evaluation

In addition to the seven components of the TRIP model outlined above, the staff of Teaching Research also believe that early childhood programs and services should be guided by the results of research and evaluation efforts. The distinction between research and evaluation is often unclear, yet both have an important place in early childhood. Research provides awareness and knowledge about hypotheses related to identified variables (e.g., developmental sequence variability, social interactions related to different interventions). Evaluation renders information related to process and outcome questions about a specific program(s) or event(s). Research activities should be conducted in order to gain new insights that affect a particular program and the general early childhood field. Evaluation should be a continuous activity that provides formative and summative information about a particular program.

One of the concerns of capturing a model in a written format is that it will have changed by the time the document goes to publication. That is certainly true of the TRIP model. The fields of early childhood and early childhood special education are evolving at a dizzying rate as the challenges of serving new populations are being met. Any model must work when put into practice and must be replicable. The TRIP model has met both of these tests. It has been demonstrated in a community preschool/child care program located on a small college campus in Oregon and replicated in numerous programs around the country. Components of the model are constantly undergoing the scrutiny of the implementation process. Do these components work for others? Can another educator be trained well enough that he or she can implement the major features of the model in a high quality manner? Both of these questions have been answered positively for the TRIP model. Due to the dynamic nature of this training program where educators view and work in a demonstration program, and where each trainee receives implementation assistance at the worksite, this program is constantly evolving.

TEACHING RESEARCH INTEGRATED PRESCHOOL
Key Program Components



Regular Data Collection and Analysis

Activity-Based Instruction

Family Involvement

Individualized Programming

Environmentally Referenced Assessment Process

Staff Management

Integration

Teaching Research Models, Monmouth, Oregon

Figure 1-1. TRIP Program Components

Table 1-1. Descriptive Information about Components of the Teaching Research Integrated Preschool Model

Integration

A variety of service options should be available within communities for children and their families. The role of professional staff should be to interface as smoothly as possible with existing community programs. The options should provide the most supportive environment possible. Based on family needs and circumstances, the family determines the appropriate service options for the child and other family members. Professionals should seek to provide a broad spectrum of options and strive to provide the highest quality of service possible.

"The philosophical, social, educational and legal data bases all point to the single fact that best educational practices means educating young handicapped and non handicapped children together" (Vincent, Brown, & Getz-Scheftel, 1981). Research indicates that integrated programs result in equal if not greater skill gain for the young children with handicaps involved in the program (Bricker & Bricker, 1972; Falvey, 1980). In addition, they provide opportunities for typical children and their parents to acquire positive information and knowledge about disabilities (Bricker, 1978; Voeltz, 1980). Although placement in integrated environments increases opportunities for interaction and learning, placement alone is not enough to ensure quality education for young children with disabilities (Fredericks, Baldwin, Moore, Riggs, & Lyons, 1978; Gaylord-Ross, Haring, & Pitts-Conway, 1984).

Activity-Based Instruction

Learning is influenced by the interaction of development and the environment. Developmental theory guides the implementation of functional curricula and instructional strategies. A child's individual instructional program should reflect developmental and environmental demands.

Beginning in the late 1970s and early 1980s researchers and educators began describing educational approaches that permitted the use of children's self-directed and unplanned or routine environmental occurrences as primary vehicles for teaching new skills (Bricker & Veltman, in press; Snyder-McLean, Solomonson, McLean, & Sack, 1984; Warren & Kaiser, 1988). The activity-based instructional approach which grew out of this movement is an integral component of the TRIP model and represents current state-of-the-art practices in early childhood special education.

Environmentally Referenced Assessment And Individualized Instruction

A comprehensive assessment system is crucial to program planning and implementation. Assessment information and data provide the blueprint for deciding what should be taught and how instruction should occur. Professional literature substantiates the importance of the need for individualized programming based on environmentally referenced assessments. The environmental approach to assessment provides a strategy for educators to determine skills needed by nonhandicapped individuals to function in a variety of settings currently available or likely to be encountered in the future by students with severe disabilities (Nietupski & Hamre-Nietupski, 1987). Research underscores the importance of careful environmental analysis in selecting instructional goals and objectives for students with severe handicaps (McDonnell, Horner & Williams, 1984; Sprague, & Horner, 1984). Snell (1983) writes, "Because of the cultural and geographic differences from one family and setting to another, all skills that are relevant for one student cannot be assumed to be relevant for another" (p. 78).

Family Involvement

In keeping with the need for individualization, research and "best practice" standards clearly support family involvement in the development and implementation of the child's educational program. Bronfenbrenner (1975) and Shonkoff & Hauser-Cram (1987) indicate that "early intervention programs which actively focus on the family or include the family as an important part on the intervention program, produced significantly greater effect on the children than did programs that did not have a strong family component." Underlying the empirical research that supports family involvement, Turnbull, Turnbull, and Wheat (1982) suggest that the importance of family involvement is the assumption that the parents have the basic right to be included in the intervention and planning process for their children. The family should be at the heart of early childhood efforts. The family should serve as a planning and decision-making participant in all aspects of its child's program.

Data Collection And Analysis

In order to maximize the benefits of routine assessment, it is important that data be reviewed regularly and used for making program-related decisions. Ongoing assessment data are collected during routine activities, and they are collected over time. Browder (1987) indicates that the most critical decisions that teachers must make concern which skills to teach and when to change instruction to improve student success. Programming changes based on tracking individual student progress is a key characteristic of exemplary early childhood services (McDonnell & Hardman, 1988).

Designated Staff Roles

Bricker (1989) suggests that sound management of the intervention staff's time and resources is an important prerequisite for developing necessary learning opportunities. Much of the staff's expertise can be wasted if systems are not designed and executed for the utilization of that expertise. Recognizing the importance of devising a plan for how to use staff, the TRIP model describes a procedure for designating staff roles and responsibilities. In addition, the model utilizes a collaborative team model for assessment, program planning, development, and implementation. The team includes classroom staff, related and support personnel. and the family.

In addition to designated staff roles and identification of an effective team approach, early childhood programs should select staff with appropriate early childhood training and experience. The training should involve an early childhood/special education course of study. Experience should include opportunities to work directly with children of all ability levels (e.g., volunteer, employment, practice). Equally important are opportunities for continuous professional development. These opportunities should include a balance of awareness, knowledge, and skill development training.

The second concern in presenting a written description of a model is that it will be viewed as a cookbook and slavishly adhered to, even in circumstances where it is not applicable. This book is intended to be used as a descriptive guide to a model of service that has attempted to solve the complexities and difficulties of change in the ways educators and caregivers work with children with special needs. It does not answer every question or meet every need. If each educator can take from the other his or her progress and knowledge and build upon that rather than starting from the same spot, then all can hope to meet the tremendous challenges ahead.

Summary

Teaching Research has been providing continued professional development to educators for 17 years. These years of training have provided a continued opportunity to test the viability of the model components. These have been tested by the practitioners--those who are in the best position to judge their effectiveness. This process of ongoing evaluation will not stop with this text. We will continue to improve, simplify, and streamline practices that are of use to practitioners who implement our collective vision of truly integrated services.

We invite you, the reader, to join this team. Using the suggested systematic, data-based approach, we invite you to try out the practices presented here and modify, adapt, and refine techniques that meet your needs.

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Chapter Two

ASSESSMENT AND IFSP DEVELOPMENT

Joyce Peters and Lisa Carlson

The word "assessment" brings a variety of issues and concerns to the minds of early interventionists. No one can deny its importance to the delivery of high quality early intervention services, but most practitioners admit to some confusion on the topic. This problem, in part, can be attributed to the differing definitions of assessment held by early interventionists.

The regulations accompanying P.L. 99-457, the Education of the Handicapped Amendments of 1986, provide the following guidelines: "Assessment means the ongoing procedures used by appropriate qualified personnel throughout the period of a child's eligibility under this part to identify:

(i) The child's unique needs;
(ii) The family's strengths and needs related to development of the child; and
(iii) The nature and extent of early intervention services that are needed by the child and the child's family to meet the needs in (i) and (ii) above" (54 FR 26306-26348).

Diane Browder defines the term as follows: "Assessment is a broad term meant to imply meaningful evaluation procedures used by teaching staff to obtain data pertinent to the instruction of students with severe handicaps" (Browder, 1987, p. vii). The Association for Persons with Severe Handicaps (TASH) provided the following definition in a newsletter article: "We will use the term assessment to mean collecting, summarizing and organizing information for decision making about individual students" (TASH, 1987, p. 2).

A somewhat different approach is taken by James Yseldyke (Salvia & Yseldyke, 1981, p. 4): "Assessment is the process of understanding the performance of students in their current ecology."

Legislation Regarding Assessments

Whichever definition one selects to work from, it appears that students are involved in the assessment process for a variety of reasons. The legislation tied to P.L. 99-457 sets some specific tasks or functions relevant to assessment that must be addressed in order for compliance to be met. The law prescribes the following procedures:

- To screen and assess children from birth through age 5 and their families, using a multidisciplinary approach
- To identify infants and young children with known handicapping conditions, those who are "developmentally delayed," and those who are at risk for developmental problems
- To engage in planning comprehensive services for young children with special needs accompanied by a model of periodic rescreening and reassessment
- To involve the family at all levels of identification, assessment and intervention (Meisels & Provence, 1989)

Types of Assessments

Interventionists must be clear on the purpose for each assessment and select an instrument designed to match that purpose. Each assessment has a separate and distinct purpose and should not be confused with each other. In developing an Individual Family Service Plan (IFSP) for children, teachers must compile a great deal of information from a variety of sources. If the IFSP is to be an accurate statement of the child's needs and those of his or her family, it is imperative that the teacher utilize the appropriate assessment tools and processes. The discussions that follow describe the five major purposes for assessment in which early intervention classroom staff are most likely to be involved.

Screening

Screening is conducted for the purpose of separating those children who appear to be developing without problems from those warranting more in-depth assessment. Screening is also designed to give early assistance to children who are at risk for health and developmental problems, handicapping conditions, and/or school failure. Classroom staff are not typically responsible for screening functions; however, some early intervention team members may be called upon to participate in agency-wide or county-wide screening clinics.

Eligibility Determination

Assessment that occurs for the purpose of diagnosis and/or program placement eligibility is often required to establish legal entitlement to a reimbursable service. This type of testing requires the use of standardized or norm-referenced tools and must be administered by licensed or otherwise qualified personnel. These are assessments that allow comparison of a child's performance to an appropriate referent group. There are two categories of norm-referenced measures: developmental scales, which are a summary of behaviors observed at various ages (e.g., Uzgiris and Hunt's Ordinal Scales of Psychological Development, 1975); and intelligence scales which are samples of behaviors observed, calculated and compared against the norm in order to determine an intelligence quotient (e.g., Stanford-Binet Intelligence Scale, 1973).

Although information resulting from norm-referenced testing may be interesting to early interventionists in indicating a child's general areas of strength and weakness, it provides little helpful information for selecting appropriate instructional goals.

Instructional Planning

It is at the point of assessment for the purpose of instructional planning that classroom staff most frequently become participants in the overall assessment process. This is the place where the link between diagnosis (determining the child's problem) and treatment (intervention or instruction) is forged. The early interventionist is responsible for pulling together a quantity of assessment information from a variety of sources in order to plan an appropriate intervention program.

Curriculum-based or criterion-referenced assessment instruments are most useful for this purpose. These tools measure a child's achievements against a prearranged or predetermined set of objectives that are the same or similar to objectives used to guide later instruction. These measures compare a child's performance to preset criteria (e.g., the criteria for mastery of an instructional objective). The results of criterion-referenced or curriculum-based assessments can be easily translated by the teacher into instructional objectives, thereby enhancing the usability of these data. Table 2-1 contains a listing of screening, norm-referenced, and criterion-referenced instruments frequently used with infants and young children.

Table 2-1. Commonly Used Assessment Instruments

SCREENING INSTRUMENTS
- Denver Developmental Screening Test
- DASI - Developmental Activities Screening Inventory
- Infant Monitoring Questionnaire
- Battelle Screening Inventory
- McCarthy Screening Test
- Functional Skills Screening Inventory

NORM-REFERENCED (standardized) INSTRUMENTS
- Bayley Scales of Infant Development
- Stanford Binet Intelligence Scale
- Gesell Developmental Schedules
- McCarthy Scales of Children's Abilities
- Wechsler Intelligence Scale for Children (WISC)
- Wechsler Preschool and Primary Scale of Intelligence (WPPSI)

CRITERION-REFERENCED/CURRICULUM BASED INSTRUMENTS
- The Portage Guide
- The Brigance Diagnostic Inventory
- The Teaching Research Curriculum Placement Test
- Battelle Developmental Inventory
- HELP Hawaii Early Learning Profile
- The Carolina Curriculum
- EPS Evaluation and Programming System

Pupil Evaluation

Another purpose of assessment is for pupil evaluation. This is closely linked with instructional planning and should be thought of as ongoing assessment. This assessment is designed and implemented by the teacher to measure progress on each objective in the child's IFSP. This progress measurement needs to be conducted on a regular and frequent basis (several times weekly). The data recorded in the process are analyzed and are used to drive decisions to make program changes. The ongoing assessment process described here may also be referred to as formative evaluation.

Program Evaluation

The final purpose of assessment to be discussed in this text is measurement conducted for the purpose of program evaluation. This is done to assess how entire programs are doing across a given time period. The individual pupil evaluation data for each classroom feed into the broader program evaluation picture. There are several issues inherent in the assessment of an educational program's worth, but two questions are of major concern:

- Are the children and families who are involved in the program making "acceptable" progress?
- Is there reasonable evidence to indicate that any observed progress is greater than if the children and families had been in alternative programs? (Bricker, 1986)

During the past 10 years, there has been a proliferation of new services to young children and their families, but few have put into place as comprehensive, program evaluation components. The need for such accountability has been reflected in federal legislation (P.L. 94-142) and by many states. For example, the Oregon Mental Health Division invested in a statewide program evaluation effort for its programs serving children with developmental disabilities, ages 3 to 5. The Oregon Preschool Assessment System (OPAS) (Brodsky, Wilson, Bailey, & Brush, 1985) was administered on a spring-to-spring basis to each child served in these programs. The Mental Health Division provided for the data to be summarized, analyzed and disseminated to sponsoring local education agencies (LEA's) as well as to each participating teacher. Although the state assumed no role in comparing district to district or class to class, the information was very valuable to the LEA in assessing the overall effectiveness of its early intervention program. Individual early intervention teachers used the information in a variety of ways to compare each child's progress against his or her previous year's gain as well as to compare the class as a whole against previous groups or against other similar groups within the same LEA. The administration of early intervention programs in Oregon has recently been passed to the Department of Education and no similar statewide evaluation effort has been instituted.

The demonstration classrooms which provide the training site for dissemination of the Teaching Research Integrated Preschool (TRIP) model, engage in a program evaluation effort on a yearly basis. There are a variety of instruments available that have been developed by early childhood programs across the country. Most contain similar items relating to the quality of program components. Appendix 1 contains a copy of the instrument that has been selected for use by Teaching Research for its own demonstration/training classrooms.

Linking Assessment, Intervention and Evaluation

The TRIP model is built on the premise that appropriate assessment is crucial to the subsequent development of functional intervention goals for children. Happily, increasing numbers of early intervention practitioners are exiting training programs with a solid knowledge base that supports the unequivocal use of comprehensive assessment information from which individual intervention objectives are selected. The number of teachers still relying on a "best guess" rationale for selecting IFSP objectives is, fortunately, diminishing; however, the continuation of this practice, even at a reduced level, should be of grave concern to parents, state leaders, and the profession.

State-of-the-art programs attach great value to an overall assessment system that provides the teacher information to guide development

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of individual program plans, supplies feedback about the degree of success a child is experiencing in his or her prescribed instructional program, and allows a means for measuring the overall value of an intervention program for a group of students. For a number of reasons, a strong relationship between program goals, assessment procedures, curricular content, and subsequent evaluation of individual and group progress should exist (Bricker, 1986). The TRIP model subscribes to a linked assessment-intervention-evaluation approach embodied in the Evaluation and Programming System (EPS) For Infants and Young Children (Bricker, Bailey, Slentz, & Kaminski, 1989). This system was designed to be used by interventionists and includes a criterion-referenced test that reflects functional objectives that can be appropriately translated into intervention objectives. These objectives, in turn, serve as a baseline for evaluation of progress and program effectiveness. A detailed description of this assessment system can be found in Appendix 2.

Steps in the Assessment Process

Earlier portions of this chapter have discussed the initial steps in the process regarding screening and eligibility determination and subsequent program placement. These two assessment activities are frequently completed prior to the teacher meeting the child and his or her family upon placement into the program. The point in the assessment-intervention-evaluationcyclewhere most teachers become involved is at assessment, for the purpose of program planning. This section will focus on the assessment processes that are implemented or facilitated by the teacher from the time the child is placed in the program, through the implementation and evaluation cycle.

Comprehensive assessment of young children must be broad based to accurately define the child's needs. The rich pool of assessment data gathered from multiple sources provides for the selection of more effective intervention goals. In addition, one set of assessment information can serve as a check to the accuracy of other information sets gathered from multiple sources.

This approach to assessing for the purpose of determining intervention goals is referred to as "multidimensional assessment" (Neisworth & Bagnato, 1988) and is defined as follows: "Multidimensional assessment refers to a comprehensive and integrated evaluation approach that employs multiple measures, derives data from multiple sources, surveys multiple domains, and fulfills multiple purposes" (p. 24).

The TRIP model delineates six key steps that comprise the process for selection of intervention goals.

Step I: Survey Relevant Environments

The early intervention teacher will, very often begin assessment with a survey of relevant environments or an ecological inventory. This is a very useful strategy for identifying skills for assessment. The rationale for using ecological inventories is to facilitate matching of selected instructional program goals to the desires of the family or the wider community in which the child lives. The environmental survey can be accomplished through report, interview, or observation to identify the skills that are performed by nonhandicapped peers in similar environments (Falvey, 1986). The student is assessed in terms of performance on those skills identified as being necessary in environments where the child currently functions and/or will be likely to function in the future. With young children, parents can often specify the settings or environments in which they would like their child to be able to participate more fully. For example, the parents might identify a local fast-food restaurant, where the family enjoys dining, as an environment to be surveyed for their 3-year-old child who has special needs. An observation of the child's peers in the restaurant might reveal the following skills being performed:

1. Child follows parent to booth or table upon entering the restaurant.
2. Child cooperates while being placed in high chair.
3. Child communicates his desired food choice.
4. Child refrains from purposefully dropping food on floor.
5. Child communicates his desire for assistance with drinking.

Other relevant environments for young children with special needs might include a kindergarten or Head Start classroom, Sunday school, local park, YMCA, or a friend's house. Regardless of the setting selected, the same process would be followed:

1. Nonhandicapped peer, who functions successfully, is observed in the selected environment.
2. Key skills or competencies demonstrated by the peer are noted.

Appendix 3 contains examples of various environmental survey instruments that are used as part of the assessment process by staff implementing the TRIP model.

Step II: Assess Student Against Set of Identified Skills

There are a number of methods for assessing children against the set of skills identified in Step I above. Preference would dictate that the child with disabilities should have a reasonable amount of time to become familiar with the target environment. Observation that occurs as the child is operating under natural and relaxed conditions would be optimum. It is wise to conduct at least two observations of the child in the setting to rule out such variables as chance, bad days or other interfering factors that could be affecting his or her performance. The observation can be enhanced to a large degree if careful planning goes into the activity(s) the child will be engaged in, the materials that are available to the child, the interaction(s) that the adult facilitator (teacher, aide, parent, etc.) will attempt with the child and, most of all, the clarity with which the observer can focus on the specific skill or skill sequence being assessed.

Practicality would dictate that some assessments will be done through interview or report from adults who are very familiar with significant aspects of the target environment. Such persons could include parents, day care providers, kindergarten teachers, Head Start teachers, Sunday school teachers, school cafeteria workers, playground supervisors, bus drivers, and so on. The interview approach would be more practical and appropriate for skills most typically needed in home environments such as dressing or bathing. Parents or caregivers would have natural opportunities to observe the child's skills in these areas and the child will be less apt to realize he or she is being "tested."

Step III: Prioritize Deficit Skills

The teacher must prioritize deficit skills in order to reduce an often immense pool to a set of skills that can be reasonably undertaken as 1 year's work. This task is often one of the most difficult in the entire assessment-intervention-evaluation cycle. When setting priorities, the teacher must consider a number of variables including the following: functionality and utility of the skill; age appropriateness of the skill; preferences of child, family, or caregivers; and the independence building nature of the skill.

Functionality and utility of the skill. The teacher will want to consider the general usefulness of the skill across activities as well as the probability of the skill having lifelong usability. Another discriminator might be the compensatory nature of the skill: Will it assist the child to compensate for sensory or other deficits? Of course, one must always consider whether or not a skill is likely to increase the child's independent performance.

Age appropriateness of the skill. With increasing placement of preschoolers with handicaps into preschools and day care centers with nonhandicapped peers, the issue of "age appropriateness" cannot be overlooked. The TRIP model is one in which the small group setting provides the context for major areas of instruction. The IFSP skill goals are prioritized and selected based on the similarity of the skill to those needed for successful functioning by nonhandicapped peers in the same setting; these could be considered as developmentally congruent skills. The early interventionist is cautioned, however, not to assume that all children, regardless of handicapping conditions, must lock step through a developmental curriculum until eventually they can demonstrate the skills observed in normally developing peers. Age appropriateness of the skill, from a developmental standpoint, must serve as a guideline only.

Preferences of the child and caregivers. Children with handicapping conditions may need to learn some skills that they do not like (e.g., toileting) but are considered necessary because of society's demands. Aside from these necessary skills, however, the prioritization decision should be based, as much as possible, on the child's preferences and family needs. Children may need to be exposed to novel activities several times before the teacher makes a judgment as to the child's preference for it. Another method is to give the child brief exposures to a variety of activities and note his or her reactions (smiles and indicates desire for continuation, avoids or attempts to pull away from the activity). Parents can be encouraged to share their preferences for skills to be targeted that would enhance their ability to involve the child more in family and community activities. Often parents express preference for skills that will generally benefit their child, such as self-sufficiency and competence in interpersonal relationships.

Independence-building skills. The importance of prioritizing so that instructional goals are selected that will maximize the student's ability to function independently cannot be overemphasized. This consideration is tied closely to that of functionality but takes on a more long-range characteristic. Most parents and professionals would agree that the goal of early intervention is to prevent or reduce the effects of handicapping conditions so that the child can function as independently as possible in the least restrictive settings with peers of the same age. Given this goal, teachers must consider each potential instructional goal in the light of how the learning of this skill will make this child more independent. The format that is selected for instruction can also feed into the enhancement of independence. Given a choice between "stringing beads" or "activating an augmentative communication device" the latter would be selected because of its immediate and long-term potential for providing the child more independence in his environment.

Step IV: Develop IFSP Goals and Objectives

The drafting of IFSP goals and objectives, which links assessment, intervention, and evaluation, is an essential component of the TRIP model. An analysis of data from curriculum-based assessment instruments, provides the base from which realistic and appropriate IFSP goals evolve. The content of IFSP provides the road map for getting from the child's beginning skills repertoire to the skills specified as the long-range goals in the IFSP (Bricker et al., 1985). The intervention goals serve as the basis for ongoing evaluation to determine whether or not the child shows improvement. A commitment to this approach is exemplified in the strategies that are used by staff in carrying out the assessment, intervention, and evaluation process.

The assessment instrument chosen for current use in the model is The Evaluation and Programming System (EPS II). This curriculum-based instrument is designed to generate outcomes that are directly applicable to the development of an IFSP. The EPS II has a number of notable features that assist teachers in translating deficit assessment skills directly into IFSP objectives: (a) each item is a legitimate training goal or objective, (b) assessment outcomes yield comprehensive coverage of important behavioral domains, and (c) there are a sufficient number of items to provide programming guidelines.

The objectives are stated in functional, generic terms as opposed to very narrow, splinter-type skills. For example, an intervention goal from the EPS II is stated, "Child places objects in a series according to length or size." This is a functional and generic skill in that it can be applied to endless objects and circumstances in the child's environments. Compare this functional goal to a typical goal historically prescribed for preschool children with special needs: "Child places five rings on a peg in ascending order."

Early interventionists may find it useful to apply some check against the quality and appropriateness of IFSP goals they develop for their students. The IFSP Analysis contained in Table 2-2 is one good example of such a check list which allows teachers to assess the objectives they've written against the major indicators of what is considered "best practice."

Steps V and VI: Develop Individual Programs and Program Formats

The development of individual programs and program formats are the final two steps in

Table 2-2. Qualities of Educational Goals and Objectives

Functionality
- Will the skill increase the child's ability to interact within the daily environment?
- Will the skill have to be performed by someone else if the child cannot do it?

Generic
- Does the skill represent a general concept or class of responses?
- Can the skill be adapted or modified to a variety of handicapping conditions?
- Can the skill be generalized across a variety of settings, materials, and people?

Instructional Context
- Can the skill be taught in a way which reflects the manner in which the skill will be used in the child's daily environment?
- Can the skill be easily embedded by the parent or teacher within home and classroom activities?

Measurability
- Can the skill be seen and/or heard?
- Can the skill be directly counted (e.g., by frequency, duration, distance measures)?

Hierarchical Relation
- Is the short-term training objective a subskill or step which is developmentally and educationally consistent with the long-range goal?

Source: Bricker, Bailey, Slentz, & Kaminski. (1989). Reprinted by permission.

the process used in the TRIP model. The details supporting these final steps will be enlarged upon in Chapter 4.

Summary

Early intervention services for young children with special needs have changed substantially in the past decade. With this expansion has come a need to refine and develop effective methods for assessing the behavioral repertoires of young children and their families. This chapter has presented an overview of the assessment strategies and procedures employed in the TRIP model.

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Chapter Three

ACTIVITY-BASED INSTRUCTION

Tom Udell

As the concept of early intervention first developed, instruction was based primarily on the application of behavior modification principles. Populations targeted were children with severe and profound handicaps who were often from institutional settings (Bricker, 1986). Structured approaches using these principles were developed. These approaches relied heavily on adult-directed instruction, artificial reinforcers, and a highly structured environment.

Through these approaches children were able to gain skills, and significant changes in behavior were produced. Frustration came, however, when children were found to have limited use of these skills outside the training setting. Skills were not being generalized across environments, materials, or trainers.

Activity-based instruction is an approach developed to incorporate behavioral principles in a way that will assist children in generalizing skills. Activity-based instruction provides direct instruction on specific skills within the context of functional and normal daily activities. In other words, it involves children in the daily activities that most children are part of and applies behavioral principles to provide needed, additional instruction.

Historically, special education practice has targeted instruction on specific skills with the idea that when mastered, the child would add those skills to his or her repertoire and produce changes that would enhance his or her abilities.

Activity-based instruction uses general activities to teach specific skills. Generalization is intrinsic in the approach. Bricker (1986) summarizes one of the primary advantages:

> One important advantage of activity-based instruction is that the skills are taught as functional behaviors. For example, if a pincer grasp is the target skill, the child should be required during snack time to use this grasp with a raisin, apple slice, or cheese wedge or during an art activity for picking up pieces of tape. This is in opposition to seating a child at a table and conducting a series of structured trials with no apparent functional outcomes (e.g., putting pegs in a board on command) (p. 291).

Teaching skills as functional behavior produces many other advantages. Generalization becomes an intrinsic part of instruction. Skills are naturally maintained because they are used. Children are motivated and, as a result, many problems with lack of attention are alleviated. Incidental learning occurs. Reliance on adult instruction is reduced and children can model from peers. Activity-based instruction enables children to function in the normal environment and still receive the level of intervention that ensures skill acquisition. It is a method that allows children to interact and be involved in activities, regardless of special needs.

Another key advantage is seen in how well this approach interfaces with designs that prevail in early childhood programs. For example, many regular preschool and child-care programs are designed around a developmental philosophy that encourages children to interact with their environment (materials, children, and adults) as part of the learning process. Children are encouraged to initiate their own activities and development is viewed as very individualized, each child progressing in his or her own way, at a comfortable pace.

These programs are also designed to provide for a wide range of developmental abilities. Once staff has been given additional information and guidance in regard to providing directives, corrective feedback, and reinforcement on specific skills, children with special needs can then effectively be involved in many regular preschool programs.

Selecting Activities

Selecting activities that are broad enough to meet the varying needs of all children is an important part of planning for an integrated setting. Activities should allow for a wide range of interest as well as a wide range of abilities. This can be done by providing choices within activities and focusing on the process and involvement of children rather than any product. An art activity allowing children to explore paints with brushes, manipulatives, and their hands can provide more opportunity for involvement than using brushes to paint a picture of a specified object. Activities must be planned not only to meet the varying individual abilities of children but also to meet individual instructional objectives. We must ensure not only that the child can be involved but that opportunities for specific targeted objectives can be incorporated.

It is also important to ensure that activities are developmentally appropriate. The concept of developmental appropriateness as defined by the National Association for the Education of Young Children (NAEYC) position statement has two dimensions: age appropriateness and individual appropriateness.

Age appropriateness refers to the predictable sequences of growth within an age span. With a knowledge of typical development, teachers can prepare the learning environment and plan activities appropriate for the age span of the children.

Individual appropriateness recognizes that each child is unique and progresses at an individual pace and with individual patterns. Teachers can combine knowledge of child development with understanding of each child's growth patterns, interests, and background.

One primary guide widely used in early childhood programs is Developmentally Appropriate Practice in Early Childhood Programs Serving Children from Birth Through Age 8 (Bredekamp, 1990).

By using developmentally appropriate practices to develop the environment and establish activities in an integrated setting we are ensuring a high quality program for all children.

Some basic considerations when selecting activities that are developmentally appropriate follow:

- Activities should focus on process and involvement; planning for activities consists of preparing the environment, not preparing worksheets, copies, pre-cutting, and so on.
- Outcomes of activities are individual and relate to the child's needs and are not based on completion of a single end product or achieving a single goal.
- Activities should be planned that allow children a variety of opportunities to move about the area, to sit or stand at a table or to lie on the carpet or on a cushion.
- Opportunities to develop social skills of cooperation, negotiation, and problem solving are incorporated.
- Activities should relate to the interests and developmental level of the age group; choices should be part of each activity.
- Activities should be child initiated whenever possible.

The information presented in Table 3-1 illustrates each of these six considerations for selecting activities that are developmentally appropriate and provides specific classroom examples.

Implementing Activities

The schedule of preschool activities must include a balance of large-group, small-group and individual activities. It must also have a balance of structured and unstructured activities. The schedule should include activities that address all areas of a child's development: physical, emotional, social, cognitive, self-care, and communication.

The following components should be included in a preschool classroom schedule:

Large Group:

- 5 to 15 minutes in length.
- Children are in one large group designed to "open" the day with activities,

Table 3-1. Selecting Developmentally Appropriate Activities

CONSIDERATIONS	EXAMPLES
Activities focus on process and involvement with the environment rather than teacher-prepared materials.	Children explore finger paints on paper. Children manipulate play dough. Children explore cornmeal going through various funnels.
Outcomes are individual and relate to child's needs.	Blocks Area - One child is developing "Grasping" while another may be building a tower with 10 blocks.
Activities provide for variety in movement and body position.	Storytime - Children may choose to sit on a chair, sit or lie on the carpet, or lie on a pillow.
Activities provide opportunities for social skills development.	Art - Teacher purposely fails to put out enough glue bottles for all the children. Outside play - A limited number of trikes, jumpropes or balls are taken out. Snack - All the bowls and napkins are placed at one end of the table, accessible to only one child.
Activities relate to the level and interest of the children.	Housekeeping Area - Numerous concrete objects are available (utensils, dishes, plastic food replicas). Dress-Up Area - Wide assortment of clothing items are available (hats, suspenders, boots, high heels, jewelry, jackets, etc).
Activities are child initiated.	Small group learning centers - Children select from four or five activity centers within the classroom. Housekeeping - An adult may enter the child's play after he has initiated playing dress-up. Blocks area - An adult enters area and offers to help build a tower, after the child has selected the blocks area.

discussion, rule-making, language, games, stories, etc.

Snack:
- 15 minutes.
- Nutritious and varied food are provided.
- This is a social time where conversation is encouraged.

Small Group Time:
- 45 to 70 min. in length.
- Children choose or are assigned to small-group learning centers.
- Each activity has an adult teacher/ facilitator.
- Activities are planned in the areas of art, crafts, dramatic play, manipulative, water play, sand play, language, math, games, etc.
- Children rotate through 3 to 4 learning centers, spending 15 to 20 minutes in each.

Gross Motor Time:
- 20 to 35 minutes in length.
- Outside play area (weather permitting) or indoor playroom.

Story and 1:1 Time:
- 15 minutes.
- The children listen to stories as a small group or individually.

Alternating structured and unstructured and active and less active parts of the schedule is important in meeting the needs of young children. The following table illustrates how one teacher scheduled the preschool day to include the considerations mentioned, as well as a child with special needs:

Table 3-2. Example Preschool Schedule

DAILY SCHEDULE	ACTIVITY TYPE	INVOLVEMENT OF CHILD WITH SPECIAL NEEDS*
9:00 Arrival	1:1 Time	Carried off bus by staff who provide indirect language stimulation while assisting with taking off coat.
9:15 Circle	Large group	On adult's lap; total assistance to participate including verbal model.
9:30 Snack	Snack	In chair; handled cup; trained staff or parent assists in feeding.
10:00 Outside	Gross Motor	In stroller under low bars; pulls self up from seat a few inches; reaches over side of stroller to grasp objects in sand box.
10:30 Learning Centers	Small group	In stander, chair or tumble form; uses switch and Able-net control unit to access toys.
11:15 Library	Story time and 1:1 time	On tumble form; uses switch to access cassette tape.
11:30 Choice	Small group	In corner chair at activity of choice which was selected using a picture board.
12:00 Dismissal	1:1 time	In stroller, assisted with coat by staff; adult provides verbal models for imitation.

*In this example, the child with special needs has cerebral palsy which involves his lower limbs. He is beginning to attempt verbal imitations and uses switches to access toys and choices.

Room Arrangement and Materials

In any well-planned early childhood program the environmental arrangement and the materials in the classroom are an integral part of implementing activities (Dodge, 1989). Each group needs a clearly defined classroom area arranged to provide space for individual, small-group, and large-group activities. Activity areas within the classrooms should be clearly defined and arranged to allow easy transitions, provide clear pathways, and minimize distractions between areas.

Each classroom should contain at least the following activity areas:

- Blocks
- Large circle
- Home center
- Exploration
- Library
- Art
- Manipulative

Shelves and dividers are used to define areas and minimize distractions. Each classroom contains a quiet area, possibly the area used for library, that includes pillows, cushions or soft furniture. Figure 3-1 illustrates a typical room arrangement.

Within each area developmentally appropriate material must be present or made available. The following is a list of suggested materials:

Block area:

- A set of 100 unit blocks
- A set of small cars and trucks (the size to

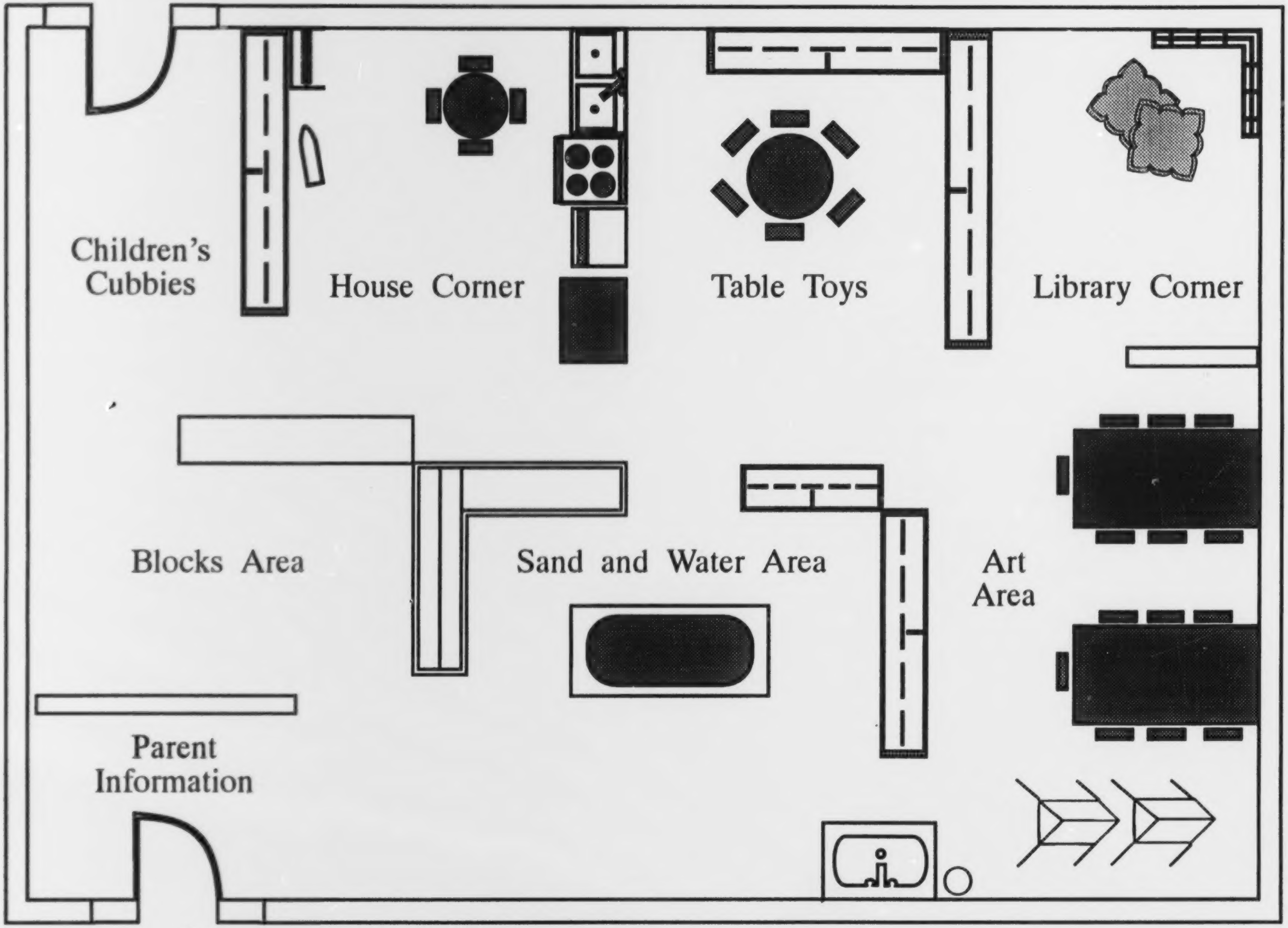
Children's Cubbies
House Corner
Table Toys
Library Corner
Blocks Area
Sand and Water Area
Art Area
Parent Information

Figure 3-1. Room Arrangement

be used as accessories to the unit blocks)

- Plastic or wooden people and animals for building accessories
- Plastic or cardboard giant blocks
- Several tubs of miniature blocks and building toys such as; Legos, inch blocks, Lincoln logs, Tinker toys, etc. (appropriate to the age group)
- Traffic sign set

Furniture:

- Stove
- Refrigerator
- Child-sized table and chairs
- Doll bed
- Nonbreakable mirror

Kitchen equipment:

- Pots and pans
- Eating and cooking utensils
- Dishes--plates, cups, saucers, and bowls
- Clean-up tools--broom or mop, dish towels, dish cloth or sponge

Dress-up Clothes:

- Jackets, skirts, dresses, shirts for boys and girls
- Shoes and boots
- Ties and scarves
- Pocketbooks and wallets

Costumes:

- Hats and tools for community helpers
- Puppets and costumes for acting out stories

Other Props:

- Dolls
- Telephone
- Food containers
- Plastic food

Library Area:

- Soft chairs or pillows
- Book shelf displaying books attractively

Manipulative Area:

- Cooperative games--lotto, dominoes, memory and matching games
- Peg boards
- Stringing beads
- Parquetry blocks
- Attribute block set
- Legos
- Other table top construction toys
- Puzzles
- Sets of Collectibles--Button boxes, Rocks, pop bottle caps, shells, etc.

Other materials will need to be individualized in order to meet each child's individual objectives.

Summary

Activity-based instruction provides an effective way to maintain the positive aspects of a data-based, behavioral approach to intervention, while ensuring generalization of skills, reducing direct teaching, and increasing motivation. Teaching skills as part of a functional routine of activities helps ensure that these skills will be generalized and maintained. Because activity-based instruction uses the environment as a stimulus and reinforcement, it reduces the amount of adult-directed teaching.

The activity-based instruction approach works well in integrated settings because it allows children to be involved in group activities and provides an arena wherein best practices in early childhood and special education can be successfully merged.

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Chapter Four

INDIVIDUALIZING INSTRUCTION

Gary Glasenapp, Constance Lehman and Torry Piazza Templeman

Preschool children with disabilities, from mild developmental delays to severe disabilities, require individualized instruction to attain goals that have been targeted in the IFSP process. The TRIP model recognizes the importance of incorporating this individualized focus into the normal daily routine of typical preschool programs.

There are several methods available for providing individualized instruction in the integrated preschool as well as several factors to consider when determining which instructional formats to use. One of the major considerations is selecting a system that lends itself to implementation in an unobtrusive manner. Maximizing "teaching moments" and doing so in a way that does not isolate the child from his or her peers takes sensitivity and skill on the part of the instructor. This chapter will describe several formats that can be used to deliver individualized instruction. The considerations involved in deciding appropriate formats will be discussed along with a technology which guides the classroom staff's decision-making process.

Once the specific instructional formats are chosen for a child, a comprehensive programming and data collection system provides consistency in instruction and the ability to objectively determine the areas where a child is making progress and when program changes need to be made. This chapter will describe the programming system used in the TRIP model to conduct and monitor programs. Examples of suggested forms are included.

Choices in Delivering Individualized Instruction

The skills targeted for instruction for a particular child are determined through the assessment and IFSP process. Once skills have been identified, the educational objectives must be translated into instructional programs for each child with special needs. To create this program, instructional elements can be combined in several ways to fit the needs of the learner, the environment, the concept, or the activity. The specialist should consider the following instructional elements:

- the environment
- the mode
- the format

Environment Options

Environment, in a broad view, simply describes the physical situation or setting in which instruction occurs for children. **Natural environment** would be the typical classroom or community setting in which all other children would participate in an activity. Most often, we would be referring to the preschool classroom as the natural environment. A **limited environment** refers to a setting in which the child would be separated from the natural environment into an area that is isolated from the distractions of the larger setting. This might typically be a small area in the classroom set apart by movable dividers.

In the vast majority of cases, skills should be taught in the natural setting. ***Only when it is determined that this setting will not be successful, should the staff consider teaching skills in a limited environment.***

Instruction in the limited environment has proven to be a successful strategy for some children for some programs. This includes children who are just developing consistent attending behaviors, who are easily distracted by the activities going on in other parts of the classroom, who need many repeated trials over a short period of time, who are first learning the skill, or who have had limited success learning the skill in the natural setting. Instruction in a limited setting may also be used for programs that were initially taught in the natural setting in which the child did not receive enough trials to learn or maintain the skill. It should be emphasized that skills that are practiced in a limited environment should also be practiced in the natural setting at the same time or transferred to the natural setting as soon as possible. The exclusive use of the limited environment does not allow children to generalize skills to natural settings.

Mode Options

Mode of instruction relates to whether or not the teacher involves children in instruction within the context of a small **group** or whether it occurs on a **one-to-one basis** involving one instructor focusing attention on only one child at a time.

The group setting has been shown to be effective for teaching numerous skills, particularly communication and social skills.

Group instruction. The majority of skills that are taught in the TRIP model are taught within the natural environment, in a **group mode**.

Special education professionals have increasingly recognized the benefits of group instruction for teaching a variety of skills. Within the integrated classroom, many skills can be acquired naturally and efficiently, in the group mode. The group mode has the benefits of peer modeling, language stimulation, and social interactions not possible in the one-to-one mode. The group setting provides opportunities to learn skills within the context of typical preschool activities. Instruction in the group can still be individualized, but the instructor-to-child ratio may be one to three, one to four, or larger.

Within the group, individual objectives do not need to be the same for each child even though everyone may be using the same materials or setting. For example, during an art activity, the group may be exploring colors through painting. The targeted goals for one child may be naming colors and cutting with scissors; for another child the goals might be to activate a switch to ask for help and following one-concept commands; a third child may be working on sharing objects and using four-word phrases. So even though all the children in the group may be engaged in a common activity, the purpose of the activity may vary according to the level of the child.

Delivering instruction in ways that do not limit or stilt the natural flow of the activity is surely the art of teaching. As our skills at embedding direct instruction (cues and consequences) into activities increases, the casual observer may not even recognize the natural flow of interactions between the child, the materials, and the adult as "instruction." For example, a classroom assistant was involved in the activities of several children at the sand table. For one child (Emma) this setting provided an opportunity to "work" on several of her IFSP goals. The children were playing with boats and figures who were "diving" for gold and treasure. The assistant asked Emma to swim her diver ***under*** her boat (an IFSP goal of prepositions). Emma happily cooperated, diving her figure under her boat for hidden treasure, clearly demonstrating a functional understanding of the concept. The assistant marked a data sheet, documenting Emma's success, and continued playing with the children.

In a typical preschool day Emma will have many other opportunities to practice and receive feedback on her ability to functionally apply the concept. Her staff will "capture" several of these attempts throughout the day by recording her responses, providing the EI specialist with an objective picture of where Emma is in learning this concept.

One-to-one instruction. Individualized instruction in the **one-to-one mode** has been demonstrated for many years to be an effective means to teach individuals with special needs. One-to-one instruction refers to instruction that occurs when there is one instructor and one child (a 1:1 ratio) working together on a skill. In fact, until recently, many professionals believed that the more one-to-one instruction we could provide, the better. We now know that many skills are more effectively and efficiently taught within activities in small groups. In spite of the recent trend to shift to more small-group and activity-based approaches, one-to-one instruction remains a viable teaching strategy for some children and for some skills.

One-to-one instruction may occur in a natural or limited environment. The majority of skills taught utilizing the one-to-one as well as the group mode should be taught in the natural environment. For example, feeding skills would naturally be taught at snack time or during lunch, hand washing would be taught after an art activity in which the child's hands got dirty with paint or glue.

For some children, it may be more effective to deliver part of their instruction in a more limited or isolated environment in which the child receives instruction that is away from the distractions that may occur in the natural environment.

One-to-one programs can occur in the natural setting or in a limited environment. Generally, a limited environment may be chosen for reasons of privacy (in the example of a toileting program) or for reasons of distractibility, as mentioned above. In such a case, efforts should be made to increase the child's tolerance to the normal distractions present in the classroom, thereby facilitating return to the group setting. Most one-to-one programs will be taught in the natural environment. For example, a child who needs special instruction on putting on a jacket may be paired with one staff member as he prepares to go out for recess. This approach provides the more intense teaching ratio (1:1) that may be needed by some children, but keeps the child with peers and learning in a natural, functional setting.

Format Options

Format of instruction refers to the teacher's choice of what approach to use in setting up or scheduling the trials of instruction. One option could be **distributed trial training** in which the trials are distributed over the course of the day and across many different settings. **Massed trial training** describes a format in which the child practices the same skill several times in succession without any intervening instruction on other skills.

In **distributed trial training**, for example, a child learning to indicate choices would practice this skill across many different environments throughout the day. The child could be given the opportunity to make choices (a) in the morning, by selecting an area of the classroom to play in; (b) at art, by choosing the colors to use on a picture; and (c) at snack, by indicating a choice in food or drink.

In each of these cases, the learning opportunity is structured to the child's level and feedback is given to the child as to how he or she performed the skill. Lastly, data are noted so that there is a record of the child's responses across these settings at the close of the day.

Another characteristic of distributed trial training is that a number of different skills may be presented during the same activity. For example, during snack, the child may be working on the skills of makes a choice, indicates yes/no, reaches and grasps an object, scoops, and signs "all done." By their nature the majority of skills taught in the group setting utilize the distributed trial format since trials from several skills occur concurrently during the group activity. The targeted skills, if functional, will also occur throughout different activities during the day. There are some skills, however, that naturally occur in a repetitive practice pattern and can be taught in a massed trial format in the group mode.

Massed trial training is effective when the child practices a single skill or part of a skill several times in succession without any trials on any other skills intervening. Massed trial training can occur in the natural environment on programs such as scooping applesauce with a spoon which would naturally occur during snack or lunch.

The earlier discussion of the one-to-one mode option includes other examples of skills taught in a **massed trial** format.

The specialist may select either format of instruction, distributed or massed trial, depending on the nature of the skill. In the example of "putting on coat," the occurrence of this skill is going to naturally be ***distributed*** over the day (outdoor times, going home). For the child who may be learning to scoop, the method of massed trial training will be chosen, since we naturally ***repeat*** this activity as we eat a bowl of applesauce.

Most skills that are taught in the natural environment employ a distributed trial arrangement since this is how the skills naturally occur. By teaching the skill in a number of different settings throughout the day the teacher is giving the child the opportunity to practice and generalize the skill in many natural situations. As was mentioned earlier in this chapter, some skills naturally occur in a massed trial pattern. These skills would be taught using a massed trial format. Any skill that needs repeated trials without the interruption of other skills is best taught using a massed trial format.

Child-related factors to be considered include such elements as how much repeated practice the child needs in order to acquire a skill, the type of skill to be taught, the distractibility level of the child, and how well the child is able to maintain and generalize new skills.

The "classroom factors" that may influence how and where skills will be taught include the number of children in the classroom, the number of staff available to conduct activities, and the availability of classroom space and materials. Classrooms that have a large number of children, a limited number of staff, and a lack of physical space or materials may out of necessity conduct more large-group activities and try to individualize a child's needs within the group setting.

The key for determining the most appropriate instructional format is to be aware of the child's general learning style and to keep in mind that the purpose for teaching the targeted skills is to enable the child not only to learn the skill, but also to be able to use the skill in a functional manner in activities that occur in daily lives.

Summary: Selecting Instructional Options

The development of individual instruction for children will ease the learning of targeted skills. Appropriate child programs, taught utilizing a variety of different environments, modes and formats, serve as the foundation of our intervention efforts.

The challenge for the staff is to determine the most effective and natural strategy for teaching skills. The decision as to which options to use must be based on the individual needs of the child. Understanding each child's special needs and learning style is crucial in determining instructional options. Of equal importance is knowing the individual strengths of each child. By recognizing needs, learning style, and strengths, the staff can assist the child in utilizing and building upon strengths as the child continues to learn new skills and practice those newly acquired. The variety of options related to environment, mode, and format are illustrated in Figure 4-1. The reader will note that the boxes containing a check in the matrix indicate an available option. The teacher can elect to combine selections from each category in several ways depending on relevant variables already discussed.

		Environment		Mode		Format	
		Natural	Limited	Group	1:1	Distributed Trial	Massed Trial
Environment	Natural	■	■	✔	✔	✔	✔
	Limited	■	■	■	✔	✔	✔
Mode	Group	✔	■	■	■	✔	✔
	1:1	✔	✔	■	■	✔	✔
Format	Distributed Trial	✔	✔	✔	✔	■	■
	Massed Trial	✔	✔	✔	✔	■	■

F4-1

Key: ✔ = possible choice
■ = not a choice

Figure 4-1. A Matrix for Selecting Instructional Options

Prioritizing IFSP Objectives for Instruction

The assessment process, described in Chapter 2, provides essential prerequisite information from which a systematic strategy is used to determine where and how IFSP objectives will be taught.

The activities matrix (see Figure 4-2) is a good starting point in this process since it provides an easy-to-use method for prioritizing IFSP objectives and skills. To use the activities matrix, the teacher begins by writing each IFSP objective across the top of the matrix. After completing the matrix for all the objectives, the staff can prioritize objectives by identifying those objectives that are needed across the most settings. You will note in the example that the skills "makes appropriate choices" and "follows two concept commands" can be practiced in all the daily activities while "washes hands" has fewer natural opportunities that occur during the day.

Since the matrix shows the natural settings in which IFSP objectives can be taught, the staff can easily see the opportunities that are available throughout the day in which the child can practice the skill. This information will be very useful for the staff when they are determining settings and activities in which to teach the skill.

The TRIP model utilizes an activity-based approach that teaches functional skills in the actual setting in which the skills will be used. If the targeted skills are truly functional they will be used in a variety of natural daily activities. Teaching skills in the natural setting also facilitates generalization of skills. In addition, since skills in our daily lives are seldomly used in isolation of each other, trials from one skill should be practiced with trials of other skills during the same teaching session or activity. This reinforces the practice of teaching skills utilizing the distributed trial format versus teaching skills in isolation in a massed trial format. This is why the majority of skills taught in classrooms implementing the TRIP model utilize a natural environment-group mode and distributed trial format.

The Programming System

A child's instructional program needs to be organized into a system which gives the person conducting the program all the information needed to run the lesson. The programming system, whether organized using a clipboard or a notebook format, includes a list of the daily activities, information relating to the functioning level of the child, the way cues are to be presented, the materials needed (if special) to conduct the program or activity, the consequences to be used, a task analysis of the skills being taught, the data forms used to record child performance, and the criterion for advancement through the program. This program information provides the basis for providing consistency in instruction across different staff and different settings.

Programming system format

Within the TRIP model, the programming system provides all the information necessary to implement a child's individualized program and to track progress. Because each child has individual needs, the specific content of each child's clipboard or notebook will be different. However the general format will retain certain components and characteristics (see Figure 4-3). (For purposes of this text the programming system will be discussed as a clipboard.)

Clipboard organization

Within the TRIP model, the clipboard system provides the information necessary to implement a child's individualized program and to track progress. Each of the forms suggested for inclusion on the clipboard is described below:

1. Distributed Trial Data Sheet - Used to track skills that are taught in the distributed trial format in a variety of activities throughout the day (see Figure 4-4).

Activity Matrix

Name ______________________

Activity	Time	IFSP Objectives						
		Makes Appropriate Choices	Follows Two Concept Commands	Washes Hands				
Arrival	8:00-8:10	X	X					
Choice	8:10-8:30	X	X					
Circle	8:30-8:45	X	X					
Manipulation	8:45-9:05	X	X					
Art/Music	9:05-9:25	X	X	X				
Exploration	9:25-9:45	X	X					
Bathroom			X	X				
Snack			X	X				
PE/Outside	10:10-10:30	X	X					
Departure	10:50-11:00	X	X					
Individual Time								

The staff then goes through each objective and identifies those settings in which the child has the opportunity to practice the skill (signified by an "X" in the corresponding column).

Daily activities that occur within the preschool setting, such as the daily schedule, are listed in the left hand column.

Figure 4-2. Activity Matrix

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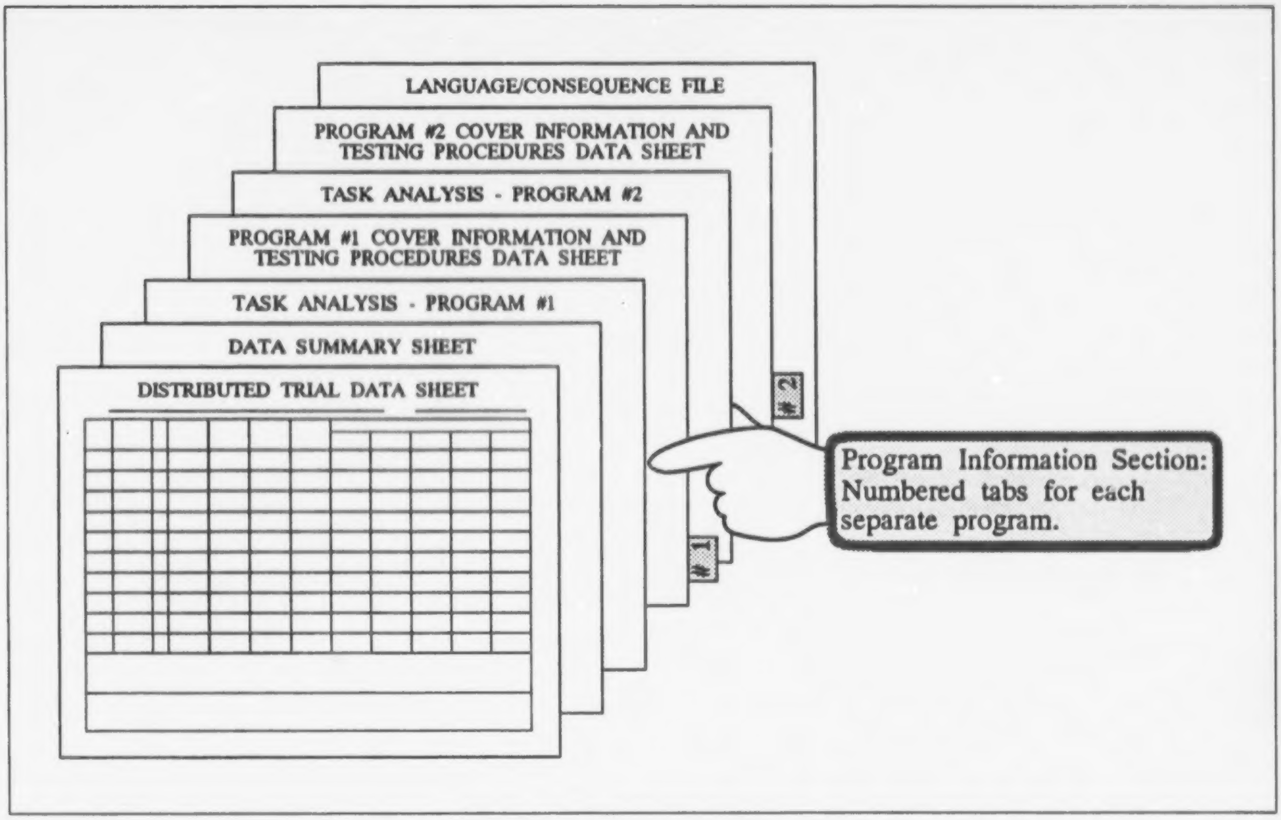

LANGUAGE/CONSEQUENCE FILE
PROGRAM #2 COVER INFORMATION AND TESTING PROCEDURES DATA SHEET
TASK ANALYSIS - PROGRAM #2
PROGRAM #1 COVER INFORMATION AND TESTING PROCEDURES DATA SHEET
TASK ANALYSIS - PROGRAM #1
DATA SUMMARY SHEET
DISTRIBUTED TRIAL DATA SHEET
#2
#1
Program Information Section: Numbered tabs for each separate program.

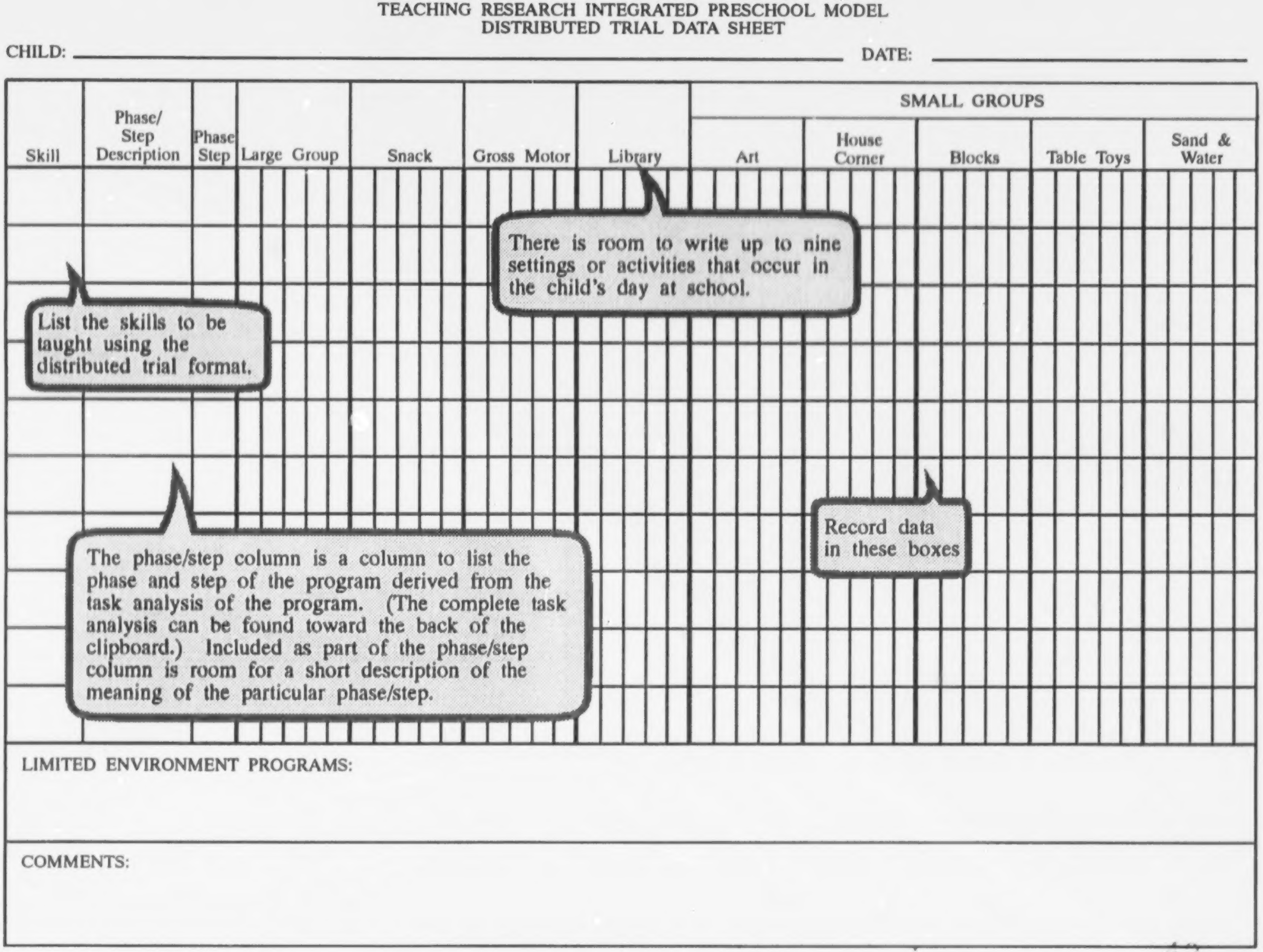
Figure 4-3. Arrangement of Information on the Clipboard

2. Data Summary Sheet - Used as a means of summarizing the child's performance from the entire day over all the settings. Information from the distributed trial data sheet is transferred onto the data summary sheet making it easy to compare day-to-day performance trends and make program decisions. The example in Figure 4-5 shows how the data from the date of 10/5 on was summarized for all programs and then transferred to the summary sheet.

3. Program Information - Provides basic, necessary information about each of the programs that were listed on the Distributed Trial Data Sheet. This information (see Figure 4-6) allows the instructor to receive (in a written record) precise information on how to implement the program. It is an ideal tool for an itinerant EI specialist to use to communicate with preschool/child care staff. Many times the community program staff are unaware of what specific goals the child with special needs may have.

Each program is identified with a numbered tab, and for each tab you will find a task analysis, Program Cover Information and a Testing Procedures Data Sheet (and, if needed, a Raw Data Sheet).

The Program Cover Information contains suggested cues or examples of cues that can be used in the teaching environment. Cues need to be individualized to the language level of each child. For a child with very limited language the teacher may specify a single or standard cue that the instructor needs to use each time. More often, the teacher may specify a menu of cues, which suggests two or



TEACHING RESEARCH INTEGRATED PRESCHOOL MODEL
DISTRIBUTED TRIAL DATA SHEET

CHILD: ______________________ DATE: ______________

Skill	Phase/ Step Description	Phase Step	Large Group	Snack	Gross Motor	Library	SMALL GROUPS				
							Art	House Corner	Blocks	Table Toys	Sand & Water

LIMITED ENVIRONMENT PROGRAMS:

COMMENTS:

There is room to write up to nine settings or activities that occur in the child's day at school.

List the skills to be taught using the distributed trial format.

Record data in these boxes

The phase/step column is a column to list the phase and step of the program derived from the task analysis of the program. (The complete task analysis can be found toward the back of the clipboard.) Included as part of the phase/step column is room for a short description of the meaning of the particular phase/step.

Figure 4-4. Distributed Trial Data Sheet

TEACHING RESEARCH INTEGRATED PRESCHOOL MODEL
DATA SUMMARY SHEET

Name Bob

Skill/Criterion	Date	10/2	10/3	10/4	10/5	10/6														

Record the date and day's data.

Washes Hands 80% 2 days

Phase/Step	IV	IV	IV	IV																
# Correct/Total	1/3	3/4	2/3	4/4																
% Correct	33	75	67	100																

Criterion for advancement

Indentifies Colors 80% 2 days

Phase/Step	I/2	I/2	I/2	I/2																
# Correct/Total	5/10	7/12	5/9	8/12																
% Correct	50	58	56	67																

Skill the child is working on

Counts 1-10 Objects 80% 2 days

Phase/Step	IV	IV	IV	IV																
# Correct/Total	8/13	6/15	6/14	5/16																
% Correct	62	40	43	31																

Discriminates Prepositions 80% 2 days

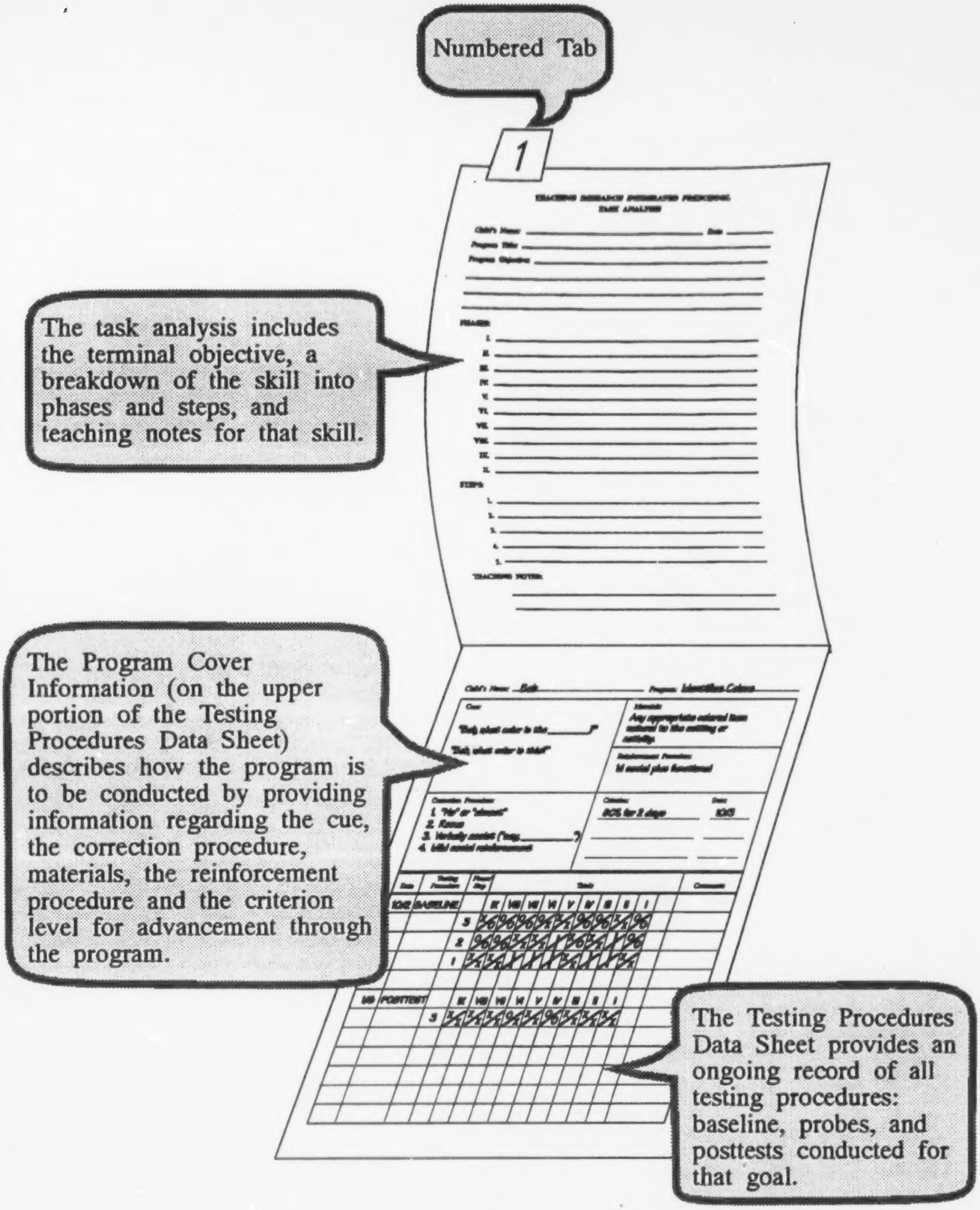
Phase/Step	II/2	II/2	II/2	II/2																
# Correct/Total	4/12	4/5	2/8	9/13																
% Correct	33	80	25	70																

Chooses Desired Object 80% 2 days

Phase/Step	III	III	III	III																
# Correct/Total	4/10	6/12	8/11	7/9																
% Correct	40	50	73	78																

Phase/Step																				
# Correct/Total																				
% Correct																				

Figure 4-5. Data Summary Sheet



Numbered Tab

The task analysis includes the terminal objective, a breakdown of the skill into phases and steps, and teaching notes for that skill.

The Program Cover Information (on the upper portion of the Testing Procedures Data Sheet) describes how the program is to be conducted by providing information regarding the cue, the correction procedure, materials, the reinforcement procedure and the criterion level for advancement through the program.

The Testing Procedures Data Sheet provides an ongoing record of all testing procedures: baseline, probes, and posttests conducted for that goal.

Figure 4-6. Program Information

more cues that the instructor may use, or simply tells the instructor to use cues that are appropriate to the play activity. Some children may respond to core cues. A core cue contains one or more key core words that must be included and the instructor has the discretion to add other words. The cue section on the Program Cover Information allows the teacher to select specific cues, menu, or core cues, or suggest guidelines for environmental cues dependent on the needs and language level of the child.

The correction procedure section on the Program Cover Information provides guidance to the instructor if the child responds incorrectly or fails to respond. The correction procedure has four parts: verbal negative feedback such as "not quite" or "almost"; the restatement of the original cue; the provision of minimal assistance either physical or verbal to ensure the behavior is accomplished correctly; and a mild social reinforcer or acknowledgement that is delivered for the completion of the task. An example for Sue might be as follows:

- Provide negative feedback -- "almost."
- Restate the original cue -- "Sue, wash your hands."
- Provide minimal physical assistance necessary to ensure that Sue completes the task successfully.
- Deliver mild social reinforcement -- "there, now you have it."

In addition to specifying how the instructor will respond to an incorrect answer, the correction procedure provides a no-fail model for the child and ensures consistency in adult responses.

In the materials section, the teacher may list specific or suggested materials needed to conduct the activity or program. Most often the materials are those already in the environment. It may be necessary to adapt/modify the materials for some children, and this section allows that information to be communicated.

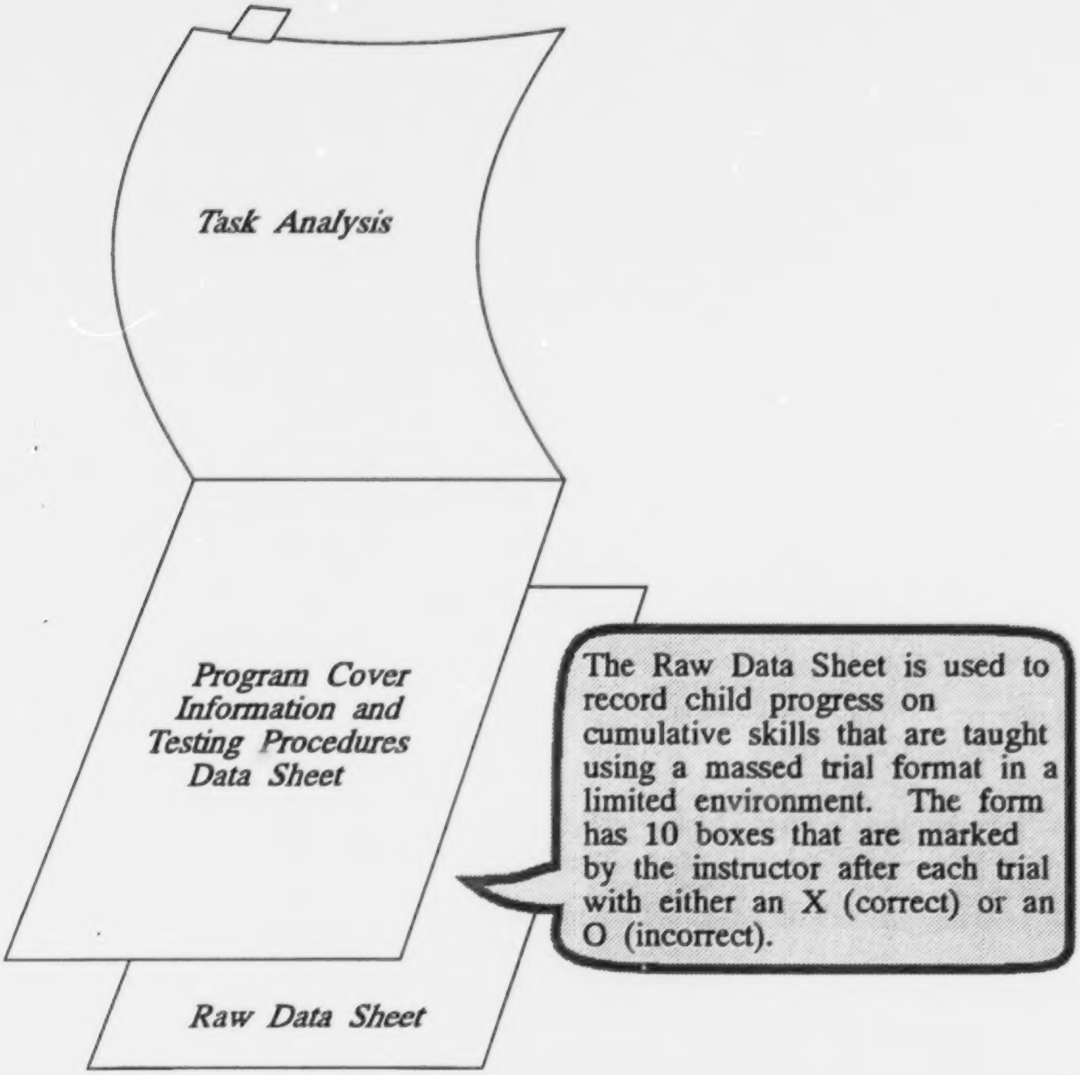
The particular type of reinforcement given for a correct response and the schedule of reinforcement delivery for a particular program or activity can also be described on the form. Usually the activity the child is engaged in and praise provide ample natural reinforcement.

The criterion level includes information about the level of performance or the number of correct responses the child needs to perform to move on to the next phase or step. The criterion level then determines the pace at which the child progresses through the task.

The criterion level should be individually determined. For children who learn fairly quickly, a relatively low criterion such as 3 consecutive correct for 1 day or 80 percent for 1 day may be sufficient. Other children may require more practice and a higher criterion level such as 3 consecutive correct for 3 days or 80 percent for 3 days. Children with physical impairments may need a more flexible criterion that takes into account "bad days." A criterion such as 80 percent for 3 out of 5 days may be more valid. The type of skill being taught is another consideration in determining criterion. Discrimination and language skills may require more instruction than self-help skills. Another factor to consider is the format in which the skill is taught. Skills taught in the distributed trial format need percentage criterions since trials do not normally occur in a consecutive manner. Skills taught in a massed trial format can utilize either a percentage or consecutive correct criterion.

If the goal has been selected to be taught in a limited environment, there is one additional page in this section of the clipboard - the Raw Data Sheet which is shown in Figure 4-7. For a more detailed view refer to the blank forms in Appendix 4.

4. Language/Consequence File - (Figure 4-8) - Contains information that gives the instructor an overview of the child. The **consequence file** contains information about


Task Analysis
Program Cover Information and Testing Procedures Data Sheet
Raw Data Sheet

The Raw Data Sheet is used to record child progress on cumulative skills that are taught using a massed trial format in a limited environment. The form has 10 boxes that are marked by the instructor after each trial with either an X (correct) or an O (incorrect).

Figure 4-7. Raw Data Sheet Placement

TEACHING RESEARCH INTEGRATED PRESCHOOL

LANGUAGE FILE, CONSEQUENCE FILE AND GENERAL COMMENTS

Student's Name Bob

Primary/Tangibles:

Toy cars

Playdough

Social: (examples)

"Give me five."

"Hey, there you go, Bob!"

1:1 time with the teacher

Skills to be Generalized:
(Give the child a chance to show you these new skills.)

Uses his words with peers.

Can fasten coat on his own.

> Bob has mastered these skills. Referring to this section allows the instructor to request the child to demonstrate skills during other activities such as during free time or snack. This will promote the maintenance and generalization of skills.

Receptive Language:

Understands most of what is said to him

> The receptive language section describes the child's current level of understanding of spoken or signed language.

Expressive Language:

Uses three-word phrases.

> The expressive language section contains a description of how well the child can communicate either verbally or through an alternative communication system. The information provided in the language file ensures that the instructor is knowlegeable about the language level of the child.

General Comments:

Is shy with peers

> The general comments section contains other essential information not already covered. Information regarding health problems (seizures, allergies, etc.) and behavior problems along with suggested treatments can be included in this section along with other information such as toileting schedules.

Figure 4-8. Language/Consequence File

the most highly reinforcing items for the child. This information can be gathered through a variety of sources, including parent interviews and observations of the child in various activities such as free time, recess, and snack. This information ensures that the instructor is utilizing reinforcers that are most important to each individual child. Also included on the language and consequence file form is a space for "skills to be generalized." This section gives the instructor information regarding skills that the child has already mastered.

Summary

Children with special needs who are placed in typical preschool settings must be provided with instruction that meets their individual needs. This chapter has discussed the options to consider to provide individualized instruction, the programming system and forms used, and the means to monitor student progress.

Chapter Five

Monitoring the Child's Progress

Gary Glasenapp

Current literature stresses the importance of data collection in programs that involve children with special needs (Baer, 1986; Fox et al., 1986; Horner, Meyer, & Fredericks, 1986; McDonnell & Hardman, 1988). The presence of a systematic data collection and analysis system has been cited as one indicator of a high quality program (Meyer, Eichinger, & Park Lee, 1987) and has been identified as a key component in the listing of best educational practices (Fox et al., 1987). Monitoring progress is also a requirement of the IFSP process.

The collection and analysis of data play a major role in facilitating a child's progress. Because many children with moderate to severe disabilities learn at a slower pace or perform skills in an inconsistent manner, the systematic analysis of instructional data is often the only means to determine whether the program is effective. It also may indicate what changes are necessary in the program to ensure continued progress. The frequent collection of data not only measures progress but also allows the child to progress at an optimal rate by allowing program changes to be made rapidly. Frequent data collection can, therefore, reveal problems that may not be readily apparent if they are collected infrequently or are not collected at all. In addition, data collected over a period of time may reveal the presence of consistent learning patterns. But perhaps the greatest benefit of frequent data collection and analysis is that the examination of the data enables the teacher to make sound, educated, instructional decisions based on precise information.

This chapter will provide the reader with an introductory discussion on the system that is used in the TRIP model to monitor a child's progress. It is not intended to be an all-inclusive description of all the intricacies of the system.

Characteristics of the TRIP Data System

Teachers of children with disabilities need a system for managing and monitoring each child's educational progress on targeted IFSP goals and objectives. This monitoring of progress is accomplished by collecting, analyzing, and making program decisions based on skill acquisition data. The TRIP model has developed a systematic process to monitor progress. This process incorporates the following characteristics:

1. The data system provides a link between the teacher and the child. The TRIP model utilizes a classroom management system in which the teacher serves as the manager. In this type of system the teacher provides some direct instruction with the children in the classroom; however, much of the instruction is the responsibility of the assistants, volunteers, and related services personnel. Examination of the data collected by these persons allows the teacher or specialist to closely monitor each child's progress even though he or she has not personally conducted the programs.

2. The TRIP data collection system allows for flexibility in the type, setting, and frequency that data are collected. Its built-in flexibility allows teachers to structure their data systems to meet the unique needs and characteristics of their classrooms and students.

3. The TRIP data system allows for the collection of data on skills as they naturally occur in functional, age-appropriate activities

throughout the day. The system provides the instructor with all the information that is needed in order for the child to practice the targeted skills, as well as to record the child's responses as they occur in a variety of natural settings and activities.

4. Instructional changes in the child's program are based upon precise data. The TRIP data system includes a systematic analysis of the instructional program data to determine their effectiveness and what changes are necessary to ensure continued progress.

These characteristics allow the classroom staff to collect data to monitor progress on programs that are conducted in an activity-based format. Once the data are collected, they are analyzed to determine what changes, if any, need to be made to increase success.

Types of Data Collected

The collection and analysis of data are seen as vital links which provide feedback in regard to the child's progress on instructional programs. The teacher must decide the amount and the type of data to be collected in order to make informed program decisions. The type of data that the teacher chooses to collect will have a direct influence on the amount of data collected. The two options, trial-by-trial and probe data, are discussed below, as are the advantages and disadvantages of each of these systems.

Trial-by-trial Data System

In this system, data are recorded on every trial of the skill. Each time the child is asked to perform the entire skill or a portion of the skill, a data point is recorded as to whether or not the child performed the skill correctly.

Trial-by-trial data may be collected in either a distributed or a massed trial format, and in a natural or limited setting. For example, John is working on a transition routine in the natural setting. Each time John moves from one activity to the next, he follows the same sequence. Therefore, if John has a total of six different transitions during the day the instructor will have six data points on this skill that record his performance throughout that day. A second example of the trial-by-trial format is of Sue who is mass-practicing the skill of writing the letters in her name in a limited setting. Each time the instructor cues her to write a letter, the instructor records whether or not Sue responds correctly.

There are several advantages to the trial-by-trial data system. Since all responses are recorded, trial-by-trial data provide the most information, as well as the most meaningful and accurate information on the child's performance.

One major disadvantage is that the recording of every response on each of the child's programs is very time consuming. By their very nature, trial-by-trial data systems require a great deal of staff time to implement on an ongoing basis. Secondly, it is not always practical to collect trial-by-trial data, particularly when there are a large number of trials given or when working with several children at the same time.

Probe Data System

The second type of data collection uses the probe data system. Probe data provide a sample of responses on a skill. This sample is intended to record the child's performance of a skill without recording how the child responds on each trial of the program.

Probe data are most frequently collected on programs that are conducted using a distributed trial format in the natural environment. For example, a child may be working on the skill "makes choices" throughout the day in all settings where there is a natural opportunity to practice the skill. However, data may be recorded in only three of the settings.

There are a number of advantages to the probe data system. First, probe data can be collected on programs in which it is not feasible or practical to collect trial-by-trial data, such as in a group setting where the instructor is involved with several children at the same time. Second, the probe data system is more practical for programs in which opportunity for a large number of trials is available. A third advantage of using probe data collection is that it allows meaningful data to be collected even in classrooms that contain a large number of children or in classrooms that have a limited number of staff. Finally, probe data collection allows some flexibility in deciding when, where, and how often data are collected.

Even though the probe data system has a number of advantages over the trial-by-trial data system, it has two major shortcomings. One shortcoming involves the amount of information that can be inferred from the data collected. Because fewer data are collected in a probe system, it is more difficult to draw conclusions from the limited information than it would be from a more comprehensive data base. Also, the sample of the data collected may not be representative of the overall performance; it may portray a more positive or a more negative picture of the child's performance than is actually true.

The TRIP model utilizes both probe and trial-by-trial data systems. Because most programs are conducted in the natural setting, utilizing a distributed trial format, the majority of data collected in the TRIP model are probe data. However, some trial-by-trial data are collected in some natural settings and on the few programs that are conducted in a limited setting.

The next section of this chapter will discuss the specific forms that are used in the TRIP model to collect both trial-by-trial and probe data in a variety of settings. This information should assist the teacher in determining the best method and data form for collecting the information needed to monitor progress and make appropriate program decisions.

Data Collection Forms

The specific data form used to collect and monitor progress in the TRIP model depends on the instructional format (distributed or massed trial) and the setting (natural or limited) in which the skill is to be taught as well as the type of skill (cumulative or noncumulative). Each of the forms has been developed to provide the teacher with a means to collect skill acquisition data in a useful manner and will allow him or her to make appropriate, educated program decisions. Each of the forms was discussed in detail in the previous chapter.

Distributed Trial/Natural Environment Data Forms

Two data forms are used to track skills that are taught using the distributed trial format in a variety of natural activities and settings throughout the day. The **Distributed Trial Data Sheet** is used to collect the data in the various settings while the **Data Summary Sheet** is used to summarize the data that have been collected throughout the day.

One-to-One Limited Environment Forms

A different data form is used when training skills utilizing a massed trial format in a limited environment. The **Raw Data Sheet** (Appendix 4) is used to collect data on cumulative skills that are taught in a massed trial/limited environment.

Data Collected During Testing Procedures

The data collection procedures and forms described to this point have referred to instructional or teaching situations. There are also a number of other occasions during the instructional process in which it is appropriate to test or verify a child's progress. These testing procedures include baseline, probes, and posttest. The following is a brief description of each procedure. A chart summarizing all the testing procedures is contained in Table 5-1.

Baseline

A baseline testing procedure occurs after a skill has been determined as an IFSP objective but before teaching begins on the program. Baseline data are collected on a behavior or skill before teaching is initiated to pinpoint what phase/step within each skill sequence a child has acquired. Therefore, for each program designated on the child's IFSP, a baseline would be completed prior to the commencement of teaching.

Collecting baseline data is a quick way to find out which parts of the skill the child already knows. The main advantage of determining a baseline is that it prevents spending valuable teaching time on a phase/step that the child may already have mastered. The TRIP model suggests a consistent form on which all testing procedures data are recorded. Figure 5-1 illustrates the baseline procedure for a sample skill.

The baseline data are kept on the clipboard with the program so they may be referred to during the updating process. The baseline also documents which phases/steps are taught in a program and which ones the child had before teaching began.

Probe Ahead and Probe Back

Periodically, a teacher will need to check ahead from the phase/step a child is working on or recheck the phases/steps already learned to validate their progress. This process of validating a child's progress is called a probe.

A **probe ahead** is used when the child easily meets criterion on a skill and is advanced to the next phase/step for a number of days in a row while making few or no mistakes. The purpose of the probe ahead is to see if the teacher can save some teaching time by checking ahead several phases/steps to see if some parts of the task analysis can be skipped. A probe ahead is illustrated on Figure 5-2.

A **probe back** is used when the child fails to meet criterion or does not demonstrate improvement after several days. The purpose of the probe back is to determine why a child is having problems at a certain level of the program. The probe back will tell the teacher whether they will need to go back and reteach a portion of the skill or whether they will have to break down that particular portion of the task into smaller increments.

The probe back is set up in the same manner as the probe ahead except the teacher is checking back instead of forward in the task analysis. If the child passes the probe back, then data indicate that the jump from one step to the next was too great. In this case the teacher needs to branch the task analysis (break the task analysis into smaller increments). Figure 5-3 demonstrates a situation in which the child fails the probe back. In this case the teacher would want to reteach the skill.

Posttest

A posttest is conducted after teaching is complete and criterion is met on the most difficult phases/steps of the program. A posttest is used to ensure that the skill has been maintained in its entirety. Only the terminal objective needs to be tested.

Data Analysis

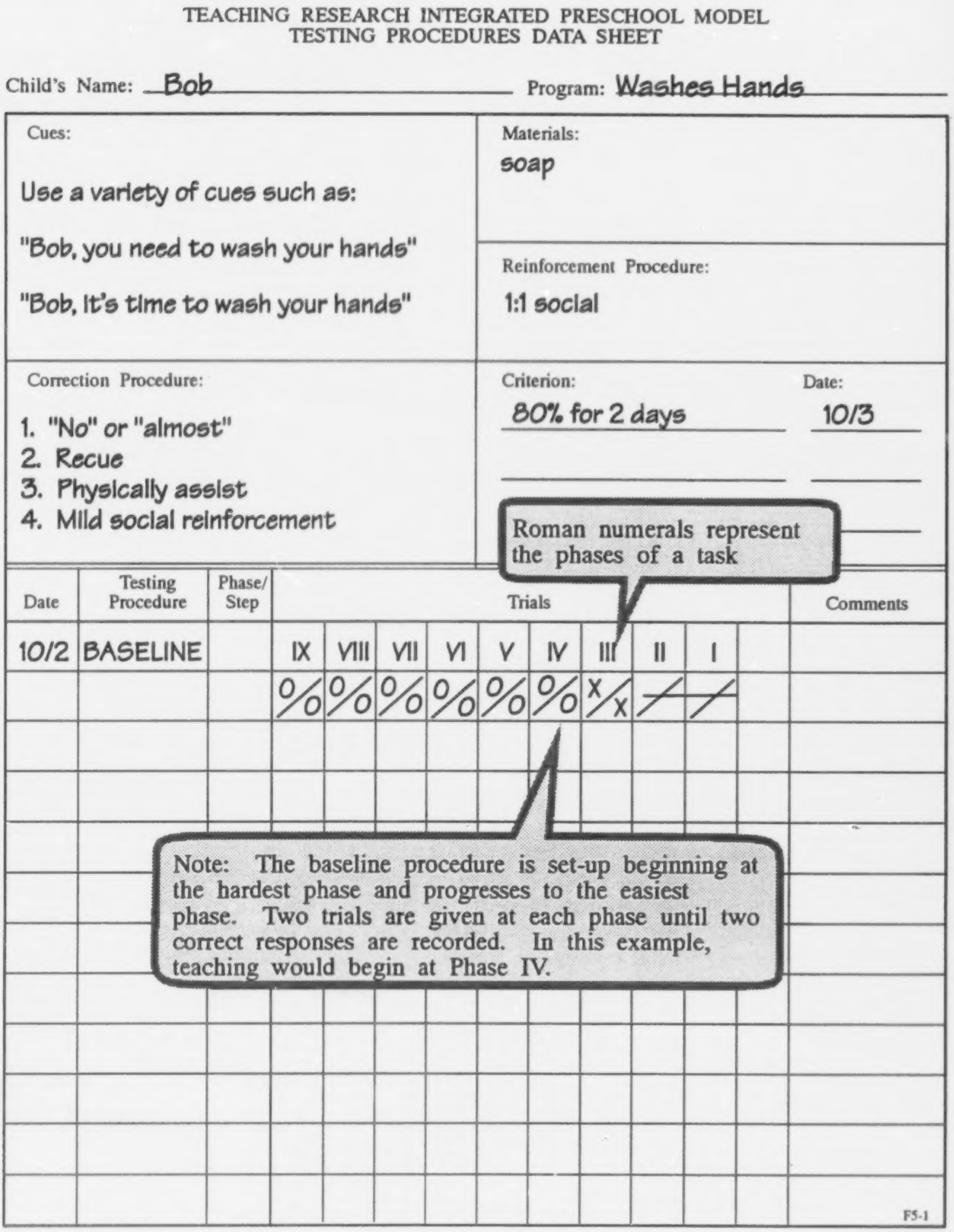
The collection of data is seen as a vital component for programs that serve children with disabilities. However, the mere collection of data does not ensure that the child will progress at an optimal rate or that the teacher will be able to make informed program decisions. Data analysis involves a three-step process, and the collection of the data is only the first step. After the data have been collected, they undergo a systematic examination to determine their meaning. Finally, a program decision is made. All three steps of this process are necessary if data are

Table 5-1

Testing Procedures Chart

	Baseline	Probe Ahead	Probe Back	Post-test
Procedure Description	Data collected on a behavior before teaching is initiated. Pinpoints what phases and/or steps within each skill sequence a student does or does not have.	Determines if phases and/or steps of the task analysis can be skipped.	Determines why child is having a problem. Will determine whether the phase/step is too difficult or if you need to reteach at a previous phase/step.	Assesses skill after teaching is completed and criterion met on most difficult phases and/or steps.
Reinforcement Procedure	Neutral social reinforcement for correct and incorrect behavior.	Primary/tangible or social reinforcement for correct responses.	Primary/tangible or social reinforcement for correct responses.	Neutral social reinforcement for correct and incorrect behavior.
Correction Procedure	No correction for incorrect responses.	No correction for incorrect responses.	No correction for incorrect responses.	No correction for incorrect responses.
Criterion	2/2	2/2	2/2	2/2
Where to begin	Begin most difficult testing phases and/or steps; discontinue at phase or step where 2 consecutive correct responses are made.	Begin at most difficult phases and/or steps which will be probed, usually 3-5 steps ahead. Resume teaching at the first phase/step where 2 consecutive correct responses are not made.	Begin at most difficult phase and/or step to be probed; discontinue at phase and/or step where 2 consecutive correct responses are made. If a child passes probe back, branch the task analysis (divide it into smaller increments). If child fails probe, reteach at first phase/step where 2 consecutive correct responses are not made.	Test most difficult phases and/or steps of the sequence. Test for generalization according to IFSP goals. If child passes posttest, maintain skill in natural environment. If child fails posttest, conduct probe-after-posttest.

T5-1



TEACHING RESEARCH INTEGRATED PRESCHOOL MODEL
TESTING PROCEDURES DATA SHEET

Child's Name: Bob
Program: Washes Hands

Cues:

Use a variety of cues such as:

"Bob, you need to wash your hands"

"Bob, it's time to wash your hands"

Materials:
soap

Reinforcement Procedure:
1:1 social

Correction Procedure:

1. "No" or "almost"
2. Recue
3. Physically assist
4. Mild social reinforcement

Criterion: 80% for 2 days
Date: 10/3

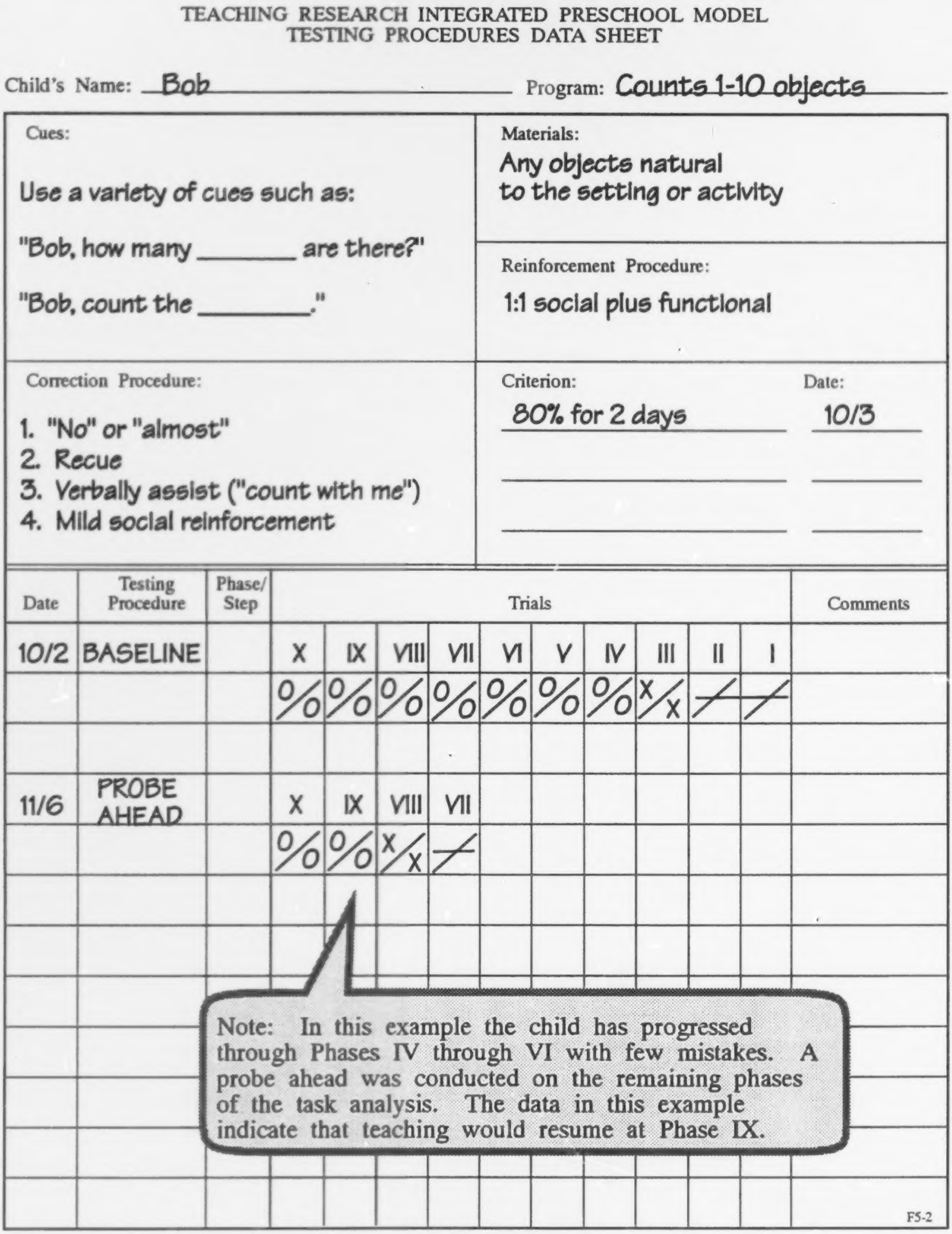
Roman numerals represent the phases of a task

Date	Testing Procedure	Phase/ Step	Trials										Comments
10/2	BASELINE		IX	VIII	VII	VI	V	IV	III	II	I		
			0/0	0/0	0/0	0/0	0/0	0/0	X/X	/	/		

Note: The baseline procedure is set-up beginning at the hardest phase and progresses to the easiest phase. Two trials are given at each phase until two correct responses are recorded. In this example, teaching would begin at Phase IV.

F5-1

Figure 5-1. Baseline



TEACHING RESEARCH INTEGRATED PRESCHOOL MODEL
TESTING PROCEDURES DATA SHEET

Child's Name: Bob

Program: Counts 1-10 objects

Cues:

Use a variety of cues such as:

"Bob, how many ______ are there?"

"Bob, count the ______."

Materials:

Any objects natural
to the setting or activity

Reinforcement Procedure:

1:1 social plus functional

Correction Procedure:

1. "No" or "almost"
2. Recue
3. Verbally assist ("count with me")
4. Mild social reinforcement

Criterion:	Date:
80% for 2 days	10/3

Date	Testing Procedure	Phase/ Step	Trials										Comments
10/2	BASELINE		X	IX	VIII	VII	VI	V	IV	III	II	I	
			0/0	0/0	0/0	0/0	0/0	0/0	0/0	x/x	/	/	
11/6	PROBE AHEAD		X	IX	VIII	VII							
			0/0	0/0	x/x	/							

Note: In this example the child has progressed through Phases IV through VI with few mistakes. A probe ahead was conducted on the remaining phases of the task analysis. The data in this example indicate that teaching would resume at Phase IX.

F5-2

Figure 5-2. Probe Ahead

TEACHING RESEARCH INTEGRATED PRESCHOOL MODEL
TESTING PROCEDURES DATA SHEET

Child's Name: Bob

Program: Discriminates Prepositions

Cues: "Bob, put the (object) _______ the _______ (object)."	Materials: Any materials that are natural to the setting or activity
	Reinforcement Procedure: 1:1 social plus functional
Correction Procedure: 1. "No" or "almost" 2. Recue 3. Physically assist 4. Mild social reinforcement	Criterion: 80% for 2 days — Date: 10/3

Date	Testing Procedure	Phase/ Step	Trials										Comments
10/2	BASELINE		VI	V	IV	III	II	I					
		6	0/0	0/0	0/0	0/0	X/X	/					
		5	0/0	0/0	0/0	0/0	0/0	X/X					
		4	0/0	0/0	0/0	0/0	0/0	X/X					
		3	0/0	0/0	0/0	0/0	0/0	0/0					
		2	0/0	0/0	0/0	0/0	0/0	X/X					
		1	X/X	/	/	/	/	/					
	PROBE BACK		IV	III	II	I							
		2	0/0	0/X	X/X	/							

Note: The child was having problems with Step 2, Phase V. A probe back was conducted on Step 2, Phases IV through I. The data in this example indicate that it is necessary to go back and reteach the skill beginning at Step 2, Phase III.

F5-3

Figure 5-3. Probe Back

to be used effectively and efficiently to make sound instructional decisions and to truly monitor child progress.

If time is invested in collecting data to monitor child progress, it follows that the teacher would commit the time to examine and analyze the data. This process of analysis is referred to as "updating." Updating is the frequent evaluation of data collected on instructional programs and the process used to modify these programs if necessary. When done properly, updating will ensure continuous progress of the child through the program and will facilitate maximum gains.

The analysis of data can also reveal the presence of consistent learning patterns. An analysis of these patterns will allow the teacher to make educated, systematic program decisions.

To be meaningful, data must be collected frequently and regularly. The teacher must have enough data to make informed decisions without spending excessive amounts of time in analysis. Several factors might influence the frequency with which data are collected: the severity of the child's disability, the skill that is to be taught, and the personnel available to collect data. It is suggested that data be collected at least weekly for all children and more frequently as dictated by the individual child's needs.

The TRIP model has developed a systematic method for collecting and analyzing skill-acquisition data and has set up guidelines for making appropriate program decisions based on these data. The forms used to collect data in the various formats and settings were discussed earlier in this chapter. The remainder of this chapter will examine the procedures and processes utilized in the model to analyze data and make program decisions.

General Updating Guidelines

The data that are collected to monitor progress in both natural and limited settings will reveal one of three patterns regarding performance:

- Success or improvement in performance is indicated when the child meets the established criterion for advancement to the next phase/step of the program or when the child's scores improve from one teaching session to the next.
- The data may indicate that there is either no change in the child's scores across teaching sessions or that there is a decrease in performance.
- Inconsistent performance occurs when scores vary substantially across teaching sessions. For example, a child may score high one day, low the next day, high the third day, and so on.

When making updating decisions the teacher is faced with two general program options: to maintain the program as is or make some change in the program. There are a number of possible program changes that can be made when it is determined that a program change is necessary. Possible changes include:

- Move the program ahead to the next phase/step when the child meets the criterion for advancement.
- Probe ahead to determine if the child can perform at a more advanced step of the program.
- Stay on the same step. The child may need an additional day(s) on the step in order to meet the stated criterion for advancement.
- Probe back to determine why the child is having a problem on a particular part of the skill by testing the mastery of the skill at a previous step.
- Change some part of the program. The data pattern may indicate that a specific portion of the program is causing the problem and needs to be changed. Possible changes include changing the reinforcer, the setting, or format in which the program is conducted, altering the program cue, correction procedure, criterion, materials, or breaking down the

skill into smaller increments.

Steps in Analyzing Data

When analyzing data, a logical sequence of steps may be followed:

1. Locate the current day's data on the data sheets.

2. Summarize the data. Add up all the data points for the day.

3. Examine the data to determine whether the criterion for advancement has been met or if the child has demonstrated improvement over the previous teaching sessions.

4. Make a decision about the next day's instruction based on the data patterns present. The teacher must decide whether to maintain the program as is or to change some part of the program.

5. Record the updating decision on the appropriate data sheet.

In order to make the best decisions, the teacher must get as much information as possible. The teacher should examine the patterns in the present day's data as well as those for previous teaching sessions. The teacher will also read the comments section since it may provide hints as to why the data appear as they do. Finally, if advancing the program, the teacher will check the baseline information to determine which phases/steps to advance to.

The following section illustrates application of these steps in updating distributed trial data.

Updating Distributed Trial Programs

The general rule for updating distributed trial programs takes into account the amount of time that it may take a child to show improvement on a particular phase or step using this format. **The updating guideline states that after three to five days of little or no success or trend toward improvement, some type of program change needs to be made.** This is intended to prevent the child from experiencing failure on the same phase/step of a program for extended periods of time.

The remainder of this section will discuss in more detail how each of these five steps is followed when analyzing data from distributed trial programs. This process can also be used to update other types of programs.

Step 1: Locate the Current Day's Data

Data from programs are recorded on the Distributed Trial Data Sheet. The data collected on targeted programs in the various daily activities and settings are recorded on this form (see Figure 5-4).

Step 2: Summarize the Data

The second step of the updating process is to summarize the current day's data. This is accomplished by adding up all the data points that were collected on the program throughout the day and then calculating the percentage of correct responses. This information is transferred to the Data Summary Sheet where it is recorded in the appropriate column. The example in Figure 5-5 shows that on Monday (10/2) the child had a total of 13 opportunities on the "counts 1-10 objects" program and correctly responded 8/13 times or 62 percent.

Step 3: Examine the Data Patterns

The third step of the updating process includes the examination of the data in relation to the previous teaching sessions in an effort to determine a pattern of performance. When examining the data the teacher is looking for one of the three patterns that were discussed earlier:

- Success or improvement in performance across teaching sessions (see Figure 5-5, "Chooses desired objects")

TEACHING RESEARCH INTEGRATED PRESCHOOL MODEL
DISTRIBUTED TRIAL DATA SHEET

CHILD: Bob DATE: 10/2 - 10/6

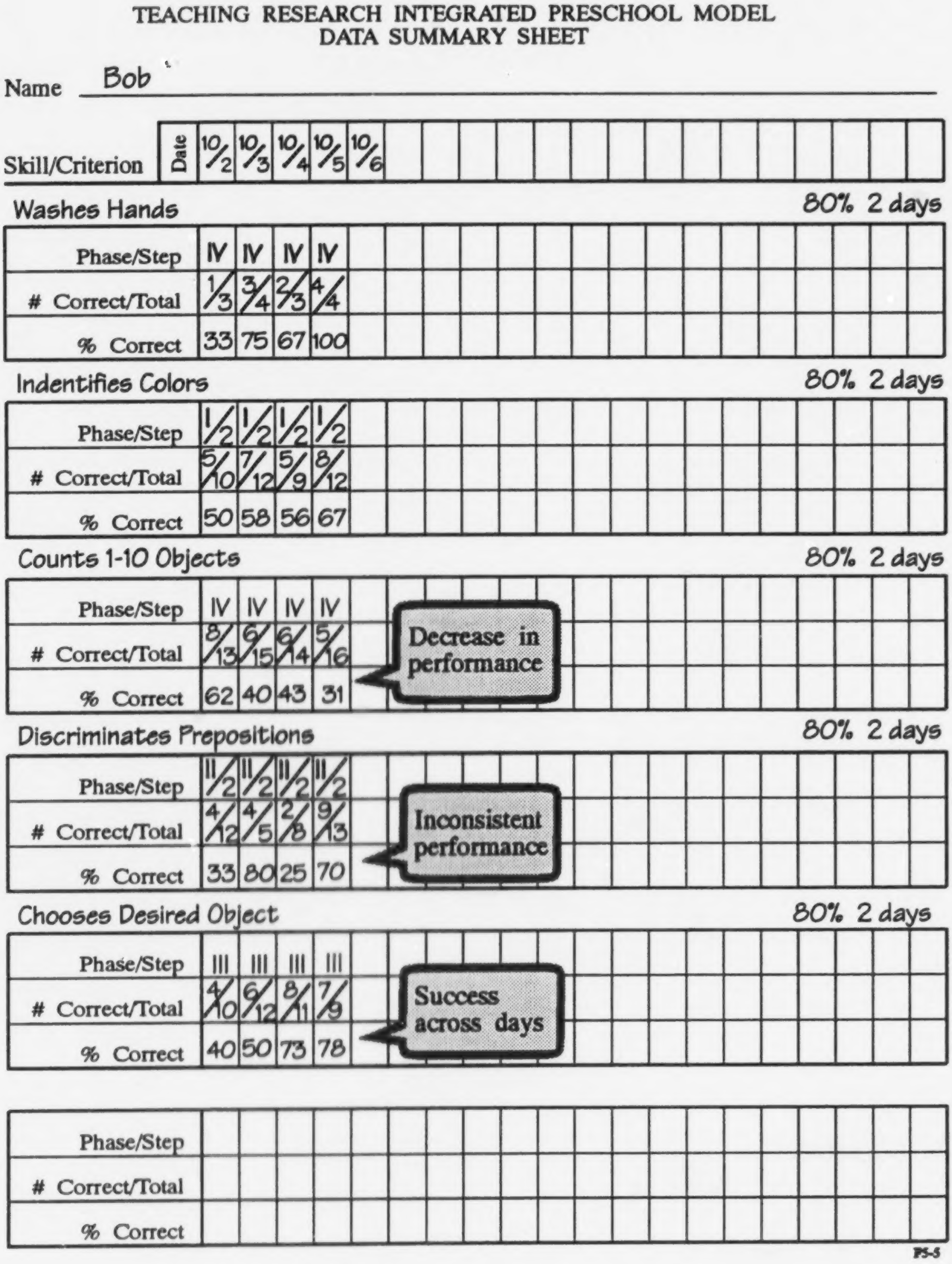
																							SMALL GROUPS																								
Skill	Phase/ Step Description	Phase Step	Large Group					Snack					Gross Motor					Library					Art					House Corner					Blocks					Table Toys					Sand & Water				
			* M	U	W	H	F	M	U	W	H	F	M	U	W	H	F	M	U	W	H	F	M	U	W	H	F	M	U	W	H	F	M	U	W	H	F	M	U	W	H	F	M	U	W	H	F
Washes Hands	Lathers soap between fingers	IV						O	X	X	X			X	X	X							X	O		X																	X	X	O	X	
Identifies Colors	Red give initial sound "r"	1/2	O O	X	O	X		X O X	X O	X X X O	X X							X	O O X		O X		O X	X O X		X X			X	O X	X O X				X			X O O		X O	X			X		O	
Counts 1-10 Objects	Counts 4 objects independently	IV	X O O	O X	O O X	O X		X O X	O O O X	O X X O	X O O X												X X	O X O X	X O O	O O O X							O	X O	O	O O		X X O X	O O X	X O X	O O O X						
Discrim Prepositions	"In" point prompt	II/2	O			X O		O O X	X X	O O X	O X		O					X	O	X O	X		O X		O O	X X		X		O			O O		O	X O			X X				O			X O X X	
Chooses Desired Object	One preferred object	III	O	X O	X	X X		X O X	O X X X	O X X	X O												X X	X O O	O X	X		O	O	X O X	O X							O O	X	X	X		O	O	X	X	

LIMITED ENVIRONMENT PROGRAMS:

COMMENTS:

* This form can be used as a weekly data sheet (as shown in this example) by assigning each data block as a day of the week and recording the data marks vertically, or it can be used as a daily data sheet by recording one data mark in one data box. A typical use is to laminate the form and use it as a daily data sheet using water-based markers for the data marks and permanent markers for the skill and phase/step description and information. After the child's daily data are recorded onto the data summary sheet the distributed trial data sheet is wiped clean of x's and o's and is ready for the next day's use. The daily water-based marks are easily removed with water; and, when updating program information re skill and phase/step, the permanent marks are removed with alcohol.

Figure 5-4. Distributed Trial Data Sheet



TEACHING RESEARCH INTEGRATED PRESCHOOL MODEL
DATA SUMMARY SHEET

Name Bob

Skill/Criterion	Date	10/2	10/3	10/4	10/5	10/6															

Washes Hands 80% 2 days

Phase/Step	IV	IV	IV	IV																
# Correct/Total	1/3	3/4	2/3	4/4																
% Correct	33	75	67	100																

Indentifies Colors 80% 2 days

Phase/Step	I/2	I/2	I/2	I/2																
# Correct/Total	5/10	7/12	5/9	8/12																
% Correct	50	58	56	67																

Counts 1-10 Objects 80% 2 days

Phase/Step	IV	IV	IV	IV																
# Correct/Total	8/13	6/15	6/14	5/16																
% Correct	62	40	43	31																

Decrease in performance

Discriminates Prepositions 80% 2 days

Phase/Step	II/2	II/2	II/2	II/2																
# Correct/Total	4/12	4/5	2/8	9/13																
% Correct	33	80	25	70																

Inconsistent performance

Chooses Desired Object 80% 2 days

Phase/Step	III	III	III	III																
# Correct/Total	4/10	6/12	8/11	7/9																
% Correct	40	50	73	78																

Success across days

Phase/Step																				
# Correct/Total																				
% Correct																				

PS-5

Figure 5-5. Data Summary Sheet

- No change or a decrease in performance across teaching sessions (see Figure 5-5,"Counts 1-10 objects")
- Inconsistent performance across teaching sessions (see Figure 5-5, "Discriminates prepositions")

Patterns are determined by checking the percentage of correct responses that have been recorded on the Data Summary Sheet over the last several teaching sessions.

Step 4: Make a Program Decision

The most important part of the updating process is determining what program change, if any, is indicated by the data patterns. The decision to make a change or to maintain the program as is, is based on the data patterns outlined above in Step 3 and follows the determination of which of the three patterns the data best exemplifies. Program decisions suggested by each of these patterns are discussed below.

Success or improvement in performance. When the child demonstrates success the updating decision would be to check the baseline and then advance the child to the next phase/step of the program. If the child meets the daily criterion, but not the criterion for advancement or shows improvement across teaching sessions, the updating decision would be to maintain the program at the same level for the following day. As long as the data indicate that the child is making meaningful progress toward criterion, it is not necessary to make any program changes.

No change or a decrease in performance. In most cases, when making program decisions, it is necessary that the teacher look at the data patterns that occur across several teaching sessions. For example, if the child's performance does not change or if it even decreases across three to five days, it is necessary that the teacher make some type of program change. There are a number of options available. The most common changes are discussed below. It should be noted that only one part of the program is changed at a time so that the change that is effective can be isolated.

1. ***Probe back***. The first option would be to conduct a ***probe back*** to determine whether it is necessary to reteach the skill at a previous phase/step or to break down the task analysis into smaller increments.

2. ***Modify the cue***. It may be that the cue is too complex for the child. The teacher might want to simplify the wording or change the type of cue.

3. ***Change the materials*** used for the program is another possible program change. It is important that the program materials be those that are found in the natural environment and are age appropriate.

4. ***Change the program criterion***. If the criterion for advancement through the task analysis is not high enough, the child may not retain the skill for more than one or two days. This problem is evident when the teacher is continually probing back and finding that they have to go back and reteach the skill at a previous phase/step. Conversely, in some cases, the criterion may be too high and not realistic for the child. For example, a criterion of 100% correct responses for 5 consecutive days might be a criterion that is setting the child up for failure.

5. ***Try branch task analysis***. Many times the problem a child encounters on a program will be related to the way in which the **task analysis** is written. The task analysis may not be broken down into small enough increments for the child to learn the skill. A branch of the task analysis is noted on the data sheet as well as a brief description of the branch. The specific branch will also be detailed on the task analysis. The teacher must remember that when the branched step is successfully completed, the next update would be to return to the original step and continue to conduct the program.

6. ***Modify the correction procedure.*** The side effects from the ***correction procedure*** may interfere with instruction and may need to be altered. For example, some children may be resistant to full hand-over-hand physical assistance. Therefore, the teacher may change the assistance portion of the correction procedure from full physical assistance to a prompt.

7. ***Change the format.*** The ***format*** in which the skill is conducted may contribute to problems in learning the skill. It may be that there are simply too many distractions occurring when the skill is taught in the distributed trial format or that the child is not getting enough opportunities to learn the skill in the natural activities. Therefore, it may be determined that the child needs additional practice in a massed trial/limited environment situation.

8. ***Change the reinforcer.*** It may be that the student is not motivated to perform the skill. This is generally not a major consideration in distributed trial programs since most reinforcers are natural outcomes to the normal activities. However, if additional artificial reinforcers are being used, it may be that these artificial motivators have lost their effectiveness and need to be changed. Inconsistent data patterns often indicate motivation/reinforcer problems.

9. ***Temporarily cancel the program.*** Finally, if a program is not succeeding and the teacher has used the most powerful reinforcers known and has made as many other changes in the program as possible, it may be necessary to put the program on hold. Temporarily canceling the program is an appropriate educational decision when the teacher has exhausted all possible modifications. This will allow the child to work on another targeted program and return to the canceled program at a future time, rather than continue in a failure situation.

Inconsistent performance. Perhaps the most perplexing data pattern is one that shows inconsistent responses across teaching sessions. There are several possible explanations for this type of pattern. Since the child is able to perform the skill at acceptable levels on certain days, the skill is obviously within the child's ability. Therefore, it appears that the child can perform the skill when he or she is motivated to perform, so the teacher may want to increase the strength of the reinforcer or alter the criterion. Or the problem may lie with some aspect of the setting. Another explanation may involve the child's disability. For example, a child with cerebral palsy may have a "bad day" due to the lack of motor control that day, but is able to perform the skill on other days when he or she is better able to control motor movements. If this is the case, the teacher may want to change the criterion so that it allows for a bad day.

Step 5: Record the Decision on the Data Sheet

The final step of the updating process is to communicate the updating decision on the child's program.

In the TRIP model, updating decisions involving changes in the cue, correction procedure, program materials, reinforcer, or criterion are made on the Program Cover Sheet. A decision to move the child ahead to the next step of the task analysis or reteach a portion of the skill should be noted on the Distributed Trial Data Sheet and should include a brief description of the new phase/step. The new phase/step should also be recorded on the Data Summary Sheet.

Branches of the task analysis should be recorded on the Data Sheet, the Summary Sheet and in the actual task analysis.

Summary

The collection and analysis of data play a major role in facilitating a child's progress. In the TRIP model, data collection is seen as a vital link which provides the teacher with feedback on the child's progress. The systematic examination of data enables the teacher to make sound instructional decisions based on objective information. In order to make these decisions, the teacher must collect data regularly and frequently.

This chapter has described several types of data that may be collected, the forms and formats used to collect the data, and how the data may be analyzed to make instructional decisions.

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Chapter Six

ENHANCING SOCIAL INTERACTIONS

Joyce Peters, Tom Udell, Lori Doede

All children need to acquire social skills. It is especially important that children with disabilities do so. Desirable social skills include understanding how to behave and what to say to others in given social situations so they will result in positive social outcomes. Examples of beneficial social outcomes include peer acceptance, being liked or accepted by significant adults, being befriended by preferred peers, and knowing how to cooperate with others. Interactive social skills usually develop when children begin to play with each other (age 30 months) and build progressively thereafter (Killoran, 1989).

Defining Social Competence

The socially competent child demonstrates the ability to successfully and appropriately select and carry out interpersonal goals (Guralnick, 1990). Related to this definition, Guralnick discusses three important implications:

1. Social competence must be related to the effectiveness or outcomes of a given social task. Important social tasks for young children include gaining entry to a peer group, resolving conflicts with parents, resolving conflicts with friends, acquiring a desired toy, and negotiating a new playground.

2. Social competence is grounded in a dynamic rather than a static process. It demands that children integrate their skills drawn from all developmental domains and organize them in some meaningful and coherent manner over time. It is the sequence that matters; it is behavior in action; it is the integration of knowledge and skills.

3. Social competence allows for individual variability in the process of seeking to achieve one's interpersonal goals. In many aspects, the construct of social competence encourages us to think about how children draw upon their individual resources to gain their ends and focuses on creative processes that are used to solve social interaction problems (p. 4).

Patterns of Social Behavior

Research studies conducted by Guralnick and associates (Guralnick & Groom, 1985, 1987; Guralnick & Weinhouse, 1984) identify certain patterns of social behaviors in children with developmental delays. Most of these children have difficulties engaging in group play, far more extensive difficulties than might be expected when one considers the children's levels of cognitive development. Solitary play is the predominant form even among 4- and 5-year-olds; the proportion of time spent in group play is minimal.

Guralnick and his associates also found an unusual absence of specific social behaviors that are typically associated in the literature with peer-related social competence. For example, these children were unable to direct and organize peers or to use them as resources. Children with developmental delays also exhibit atypical developmental patterns. For example, at the end of the school year, or when new classmates are introduced, any gains in peer interactions decline.

According to Guralnick's studies, these children also find it extremely difficult to form reciprocal friendships in spite of being highly interested in their peers, discriminating among them, and developing preferences for specific playmates. The friendships remain unilateral;

few playmates whom they choose as friends choose them in return. In comparison to appropriately matched groups of nonhandicapped children, developmentally delayed preschool children do not effectively use important social processes. For example, requests tend not to be mitigated, often creating a confrontational atmosphere. There is little variation in follow-up requests; only minor evidence of compromise or negotiation has been found; and children with delays tend not to accept alternative proposals very readily. Finally, research conducted in mainstreamed settings has revealed that, in comparison to nonhandicapped peers, children with delays are rated lower on peer sociometric measures, tend to be chosen less frequently as play partners by their peers, are used less frequently by their peers as resources, and serve as models for others less often.

The Challenge to Early Intervention Programs

Social skills deficits have immediate and long-term effects on young children with disabilities and their families. These deficits are known to result in poor self-esteem, difficulty in forming friendships with nondisabled peers, and disproportionate placement in segregated, restrictive settings.

The challenge to early interventionists is to promote the social competence of these children by placing them in appropriate social settings, and systematically using documented and proven strategies.

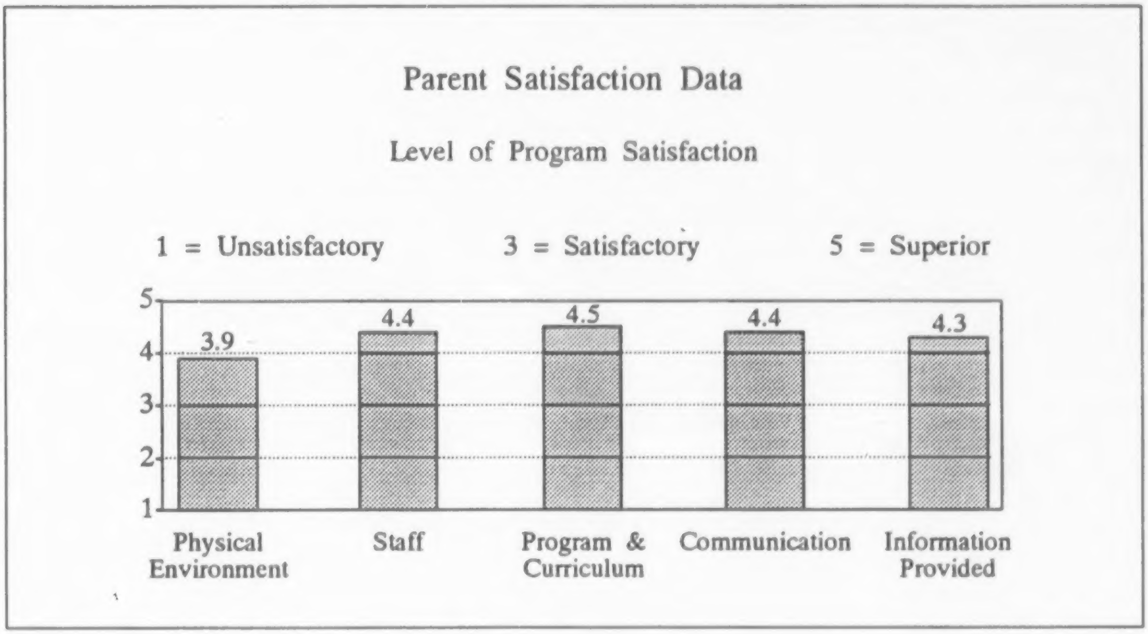
There is ample support from numerous investigators that, in comparison to segregated, specialized programs, mainstreamed or integrated programs yield interaction patterns that are more responsive to a handicapped peer's initiations, are more socially interactive overall, place important and developmentally appropriate social demands on the children, and provide extensive opportunities for observational learning (Guralnick, 1986).

The enriched nature of the communicative environment provided by nonhandicapped children to their classmates with disabilities should be of significant interest, as well. Bricker (1986) points out that early social-communicative exchanges between children and their social environment may serve as an important foundation for the conceptual and more advanced pragmatic structure of later language usage. Acquiring nonacademic, social and communicative skills is essential for success in school and in later life. As MacMillan (1977) and Zigler (1984) report, the reasons that retarded populations fail to adjust to social and vocational environments are often due to noncognitive factors, such as low social skills and negative personality variables.

Teaching Research staff in the agency's integrated Child Development Center (a community-based day care/preschool program serving children 0-6 on a countywide basis) conducted a study to determine the effects of full integration on the children with disabilities. Interactions and play behavior under the conditions of full integration and scheduled integration (1 hour per day) were compared. The results indicated that, within the experimental group (children with developmental delays, fully integrated), a significant difference was noted between pre- and posttest scores relative to their interactions with nonhandicapped peers. The experimental group also demonstrated a greater degree of change between pre- and posttest scores in parallel play. Significant changes were noted as well in cooperative play on the part of experimental group children (Templeman, Fredericks, & Udell, 1989).

Parents of children attending the Teaching Research Child Development Center program routinely complete a parent satisfaction evaluation of the program at the conclusion of the school year. An analysis of parents' responses to the wholly integrated program are summarized in Figure 6-1.

Part I. Average Ratings of Responses to Questions given with Likert Scale



Part II. Percentage of Positive Answers to Open-Ended Questions:

Parent Survey Open-Ended Questions	Positive Responses over Total Responses	Percentage of Positive Responses
How do you think staff members feel about you and your child?	22/23	96
Are you a welcome visitor in the program?	19/23	83
What are your feelings about the program being integrated?	21/23	91
What do you like best about the program?	21/23	91

F6-1

Figure 6-1. Parent Responses to Wholly Integrated Program

Facilitating Positive Interactions Among Children

There are a variety of effective ways to set the stage and provide ongoing support for positive interaction among children in integrated settings. Providing ongoing information about handicapping conditions and using a small group strategy such as cooperative goal structuring have proven effective in TRIP classrooms.

Teach About Handicapping Conditions

A simple approach to teaching children about handicapping conditions has proven most effective. As with all teaching for young children, a positive environment, good models, and concrete and relevant information is very important.

A positive environment that reflects an appreciation of diversity will generate an attitude of inclusion and appreciation of differences among the children. An appreciation of diversity can be seen in a classroom where children can physically participate in all areas of the environment, where activities are designed to include all children, and where adults model positive attitudes about individual differences.

This adult modeling plays a very important part. The comfort level displayed by adults in dealing with problem behaviors, the physical needs of children with health and physical impairments, diverse communication levels, and so on, will influence the comfort levels of the children.

During interactions with children, adults should emphasize similarities and be comfortable in answering questions about differences. Adults should provide concrete information when the child asks a question. The resulting information will be timely and relevant to the child's interests about handicapping conditions. Answering children's questions on an ongoing basis and using a child's actual experiences help to keep information concrete.

Children ask questions to both receive information and to alleviate fears and uncomfortable feelings. The suggestions in Table 6-1 are helpful in providing children with needed information as well as developing good attitudes about personal differences. Answering questions about differences that children see in other people or in themselves, can sometimes be difficult, especially when these differences relate to obvious handicapping conditions.

Table 6-1. Guidelines for Answering Questions About People's Differences

1. Be brief and factual. Children absorb information in small doses.
2. Give your undivided attention, if possible, so you can observe the child's response.
3. Use simple concrete words or metaphors the child understands (e.g., "Hearing for Pam is like listening to someone whisper.").
4. Remember that the attitude you convey during your discussion is as important as the content you give.
5. Be empathetic. Try to understand and identify with the child's concerns.
6. Be congruent. Be sure your content and attitude are consistent. Laughing at a child's clever, though rude, remark as you reprimand him or her gives a mixed message.
7. Reflect on the underlying thoughts and feelings as well as the content of the child's questions.
8. Remember to emphasize people's similarities not just their differences.
9. If talking about specific people remember to refer to the person and not their handicapping condition (for example: "Johnny" vs. "the crippled boy").
10. Avoid using labels when answering questions.

Employ Small Group Strategies

A classroom structure allowing children to work in small groups is encouraged as a

Developmentally Appropriate Practice (Bredekamp, 1990) and has been found to be successful in facilitating interactions among children of varying developmental levels (Stainback, Stainback, Raschke, & Anderson, 1981). See Chapter 3 on activity-based instruction for more information about grouping and schedules. Encouraging children to progress through a hierarchy of levels of play and using cooperative goal structuring are two effective strategies that can be implemented in a small group structure.

Determine levels of play. Children progress through a hierarchy of play levels, moving from being unoccupied to playing cooperatively. When adults working with the children recognize this hierarchy they can begin to use it to encourage higher levels of play. Adults must first observe the children and determine where a child is presently functioning and then begin to encourage the next level. Techniques are specific to each level being encouraged (see Table 6-2); however, some general rules do apply. Adult modeling is a very effective tool when working in any setting. Adults should model appropriate social responses as well as cooperative play interactions. Communication attempts between children should always be reinforced, ideally by the natural response of peers. However, if this does not occur, the adult facilitating should model a response and, at the same time, reinforce the communication attempts.

Always remember to do the following:

- Always reinforce verbal and nonverbal communication emitted by the child.
- Always reinforce peers when they initiate and/or respond to your child.
- If a peer does not respond to your child, model a response for the peer, if the peer adopts the response then reinforce the peer.

Activities that encourage interaction should always be available. Activities such as building with blocks, cooking, making a mural, or playing a game are all examples of activities designed to encourage interaction.

Use cooperative goal structuring. Most preschool classroom activities have an underlying goal structure. This structure can be based on a competitive, individual, or cooperative approach. A competitive approach is one in which children are motivated by seeing who can finish first, do the most, or be the best. An individual approach is present when children are motivated by individual outcomes, that is, children are encouraged to put away what they played with, do their own work, or do more than last time. A cooperative

Table 6-2. Encouraging Higher Levels of Play

If your child:	Encourage:	By:
Is unoccupied	Independent play, i.e., play with a toy near other children.	Placing him/her with a toy near the other children. +R for manipulating toy.
Is observing or playing independently.	Parallel play, i.e., playing beside other children with similar toys.	Placing him/her between other children. Encourage peers to share toys and +R when they do. +R your child for proximity and playing with similar toys.
Is participating in parallel play.	Cooperative play, i.e., working together with one or more children. Interaction between children, pretend play with roles, turn taking, etc.	+R peers for conversation and sharing toys. +R children for all interactive play. If your child leaves the setting direct him/her to engage in the activity again. +R when they re-enter the group.

approach motivates children with a common group goal and encourages children to clean up together before moving on, or encourages them to complete one project together.

Cooperative goal structuring is effective in producing positive interactions among children (Johnson & Johnson, 1986). A classroom structure allowing children to work in small groups is encouraged as a developmentally appropriate practice (Bredekamp, 1990) and has been found to be successful in facilitating interactions among children of varying developmental levels (Stainback, Stainback, Raschke, & Anderson, 1981). A cooperative approach is considered to be the most appropriate for young children (Bredekamp, 1990). Johnson and Johnson conclude that a positive outcome of mainstreaming is dependent on the use of cooperative goal structuring. They go on to say that this structure helps develop positive relationships and maximize social development of children regardless of handicapping conditions.

Cooperative activities would include the following:

- Cleaning-up activities as a group and moving to the next activity after clean up is completed.
- Finger painting as a group on one large piece of paper.
- Building one house with blocks.
- Completing one large floor puzzle.
- Working on a cooking project with a role for each member of the group.
- Compiling a book with a picture from each member of the group.

Cooperative goal structuring is a simple approach, easily incorporated into early childhood settings. It is promoted as a developmentally appropriate practice and an effective integration strategy.

The development of social competence in young children spans the childhood years and requires consistent modeling and feedback from all relevant adults in the child's community. These include parents, other relatives, teachers, and classroom staff. It is a process that can be at times both frustrating and contrary to the natural inclinations of the young child. Most early childhood programs have found that consistent application of an agreed-upon set of responses assists children to begin making more socially appropriate choices in their responses to events and to other children in the environment.

The Teaching Research staff has a history of over 20 years of working with young children, their families, and their teachers in the area of social skills development. An outgrowth of this experience has been the design of a proven process for responding to the typical day-to-day problem behaviors displayed by all young children, whether disabled or not.

Rules of Thumb for Managing Behaviors

"Rules of Thumb" for managing behavior identifies behaviors, categorizes them, and prescribes a response. The behaviors are those that most educators would consider inappropriate and for which they would want to teach alternative behaviors. The process is simple and provides quick responses that are respectful of children.

The case for using Rules of Thumb in an integrated setting is based on effectiveness and children's need for a consistent, clear, and predictable approach to guidance. In most cases, establishing and implementing Rules of Thumb corrects the majority of inappropriate social behaviors and provides a manageable way to teach appropriate social strategies in the preschool setting.

Several studies have shown that children are more likely to comply with expectations and demands when adults are firm, expectations are clear, rules and expectations are consistent, alternatives are offered, and children are informed of consequences (Osborn, 1983). The rules-of-thumb approach provides a means of establishing this consistency and maintaining it across a number of adults working in a classroom. Adults, regardless of their educational background and level of prior experience, can be trained to identify and categorize behaviors and then provide the established response.

One of the most important aspects of using a consistent approach is establishing a positive, supportive, and encouraging environment for children. To establish this environment, adults must be quick to offer support in the form of praise and encouragement. Studies have shown (Fredericks et al., 1982) that a four-to-one ratio of positive comments to negative or corrective comments is the minimum ratio needed to create a supportive environment. Children begin to have less positive feelings when a ratio lower than four to one exists. Highly positive and encouraging teachers find that their typical ratio can be as high as 15 positive to every negative or corrective comment.

There are a variety of ways to reinforce children in a preschool setting. Social reinforcers such as a hugs, pats on the back, and words of praise or appreciation are considered the most natural and are most commonly used by teachers and parents. A tangible reinforcer is an item or activity a child enjoys that is used for a reward. These may include food, playing with a toy, or getting to do a preferred activity. A basic rule in the use of reinforcers is to rely on the natural reinforcers present in the setting. It is also important to use reinforcers that encourage a child's self-motivation (Hitz, 1989). However, for a child with special learning needs, natural reinforcers from the environment are frequently not sufficiently powerful, and it may be necessary to exaggerate or use artificial reinforcers (Fredericks et al., 1982).

Hitz (1989) refers to effective praise as "encouragement" and offers the following as useful guidelines:

- Offer specific feedback rather than general comments. For example, instead of saying, "Terrific job," teachers can comment on specific behaviors that they wish to acknowledge.
- Initiate the praise and offer it in private. Child-solicited praise from teachers has less effect than teacher-initiated praise.
- Focus on improvement and efforts rather than evaluation of a finished product.
- Use sincere, direct comments delivered in a natural voice.
- Avoid competition or comparison with others.
- Help children develop an appreciation of their own behavior. Saying, "You must feel proud that you did that all by yourself," rather than, "I'm proud of you," helps the child to develop self-evaluation and self-appreciation.

Remember reinforcement must be geared to each child's level of understanding and interest. The general rule is to use as natural a reinforcer as possible.

Establish Rules of Thumb

The first step in establishing a rules-of-thumb approach is to identify frequently occurring behaviors that staff view as problems within the classroom. This should be a brainstorming session in which all adults who work with the children participate. Many different behaviors and variations of similar behaviors are listed. Typically, the lists will include such behaviors as tantrumming, throwing toys, whining, leaving the group, and so on.

After a list of behaviors is established, categories are formed by grouping similar behaviors. When grouping behaviors, look for similarities in the result of the behavior and the motivation for the behavior. As these groups of similar behaviors are refined and narrowed, they become the categories from which responses will be prescribed. A few broad categories facilitate consistency. It is advantageous to continue narrowing behavior groups until four or fewer categories are established.

The final step is to define the prescribed response to each category. These should be clear responses, respectful of the child and in accordance with the program's philosophy.

Rules of Thumb Examples

The following are examples of behavior categories and prescribed responses that have been used in Teaching Research preschool classrooms for many years.

Self-indulgent. Self-indulgent behavior includes whining, tantrumming, continued crying when not hurt, negative comments, pouting, and any other behavior that is considered "attention getting." The prescribed response to self-indulgent behavior is to ignore the child and behavior until it has stopped for a short period of time, then socially reinforce appropriate alternatives.

Non-compliance. Non-compliant behavior is failure to complete a task or follow a request. This includes failure to comply, not following known routines, breaking known rules, complying slowly, and poor or incomplete performance. The prescribed response for non-compliant behavior is to assist the child to follow through on the command and mildly socially reinforce. An example would be leading a child through the task of cleaning up blocks. The second alternative for a child that resists being assisted is to postpone the next reinforcing activity until he or she complies. A good example of this is having a child wait to join the other children outside until blocks are cleaned up.

Aggression. Aggressive behavior is any verbally or physically hostile act toward another person or object. This includes hitting, pinching, biting, throwing toys, and destroying property. The prescribed response for aggressive behavior is immediate interruption of the aggression and removal from the area for a short time or "time out." Time out is the withholding of reinforcement. Examples could be having a child sit in a chair near the group activity, ignoring a behavior, or refusing to let a child participate. Isolation is considered aversive and should not be used. The following guidelines will help with the effective use of time out:

- When a child is asked to leave the group, position him or her as near the group as possible.
- The length of time out should be individual to each child, but no longer than 1 minute for each year of age.
- The behavior warranting time out is briefly and clearly stated to the child.
- The procedure ends with a positive affirmation of the child.

Self-stimulation. Self-stimulatory behavior is repetitious behavior that is self-injurious or interferes with regular participation in activities. This includes head banging, eye gouging, hitting, biting, or scratching one's self. The prescribed response for self-stimulatory behavior is to interrupt the behavior verbally and physically and then redirect the child to constructive behavior. A child biting his hand during an art activity would be told to "stop" while being physically assisted to take his hand from his mouth.

Table 6-3 summarizes the Rules of Thumb developed by staff at Teaching Research.

Consider the Environment When Using a Rules-of-Thumb Approach

An integrated preschool setting is a complex setting in which to address a specific behavior. The broad range of levels at which children function, the activity level, and the amount of stimulus provide many variables that need to be considered when shaping behaviors. The use of Rules of Thumb creates consistency within the classroom and thereby reduces the occurrence of many problem behaviors. For the majority of children, this approach is sufficient for managing troublesome behaviors. There may come a time, however, when the rules of thumb will not work in a particular case. If specific behaviors become a problem across the entire group, the teacher should

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Table 6-3. Rules of Thumb

CATEGORY OF BEHAVIOR	EXAMPLES	TREATMENT	
NON-COMPLIANT	Failure to comply Breaking known rules Complying slowly Poor or incomplete job performance	When behavior occurs	When not occurring (socially appropriate)
		(1) Assist child to follow through on the command and mildly socially reinforce or (2) Withhold next reinforcing activity until compliance.	Reinforce for compliance
SELF-INDULGENT	Whining Continued crying if not hurt Pouting Muttering Cursing Negative comments Tantrumming (Attention getting behavior)	When behavior occurs	When not occurring (socially appropriate)
		IGNORE	Reinforce appropriate behavior
AGGRESSIVE	Hitting Spitting Biting Kicking Throwing things	When behavior occurs STOP/ INTERRUPT	When not occurring (socially appropriate)
		TIME AWAY FROM GROUP	Reinforce pro-social behavior
SELF-STIMULATORY	Head banging Hitting self Biting self Scratching self	When behavior occurs	When not occurring (socially appropriate)
		INTERRUPT/ REDIRECT BEHAVIOR	Reinforce appropriate behavior

evaluate the environment. For example, if children are fighting over toys it may be an indication that there are not enough high-interest toys available in an area. The chart in Table 6-4 can be used for troubleshooting environmental problems.

In another case, the preschool teacher notes that a child whom we'll call Sarah becomes aggressive toward other children nearly every day at 11:00 a.m. Even though Rules of Thumb is consistently applied in response to Sarah's aggressive behavior, she persists in the pattern.

The teacher should begin asking herself some questions about Sarah's behavior: Why is it occurring every day at the same time? What is Sarah trying to communicate to the adults in her environment? What is Sarah attempting to gain or acquire through her behavior? If the teacher discovers that Sarah becomes very hungry and out of sorts by 11:00 a.m., she can provide her a bit of cheese or a few peanuts and enable her to make it until lunch time and avoid the aggressive outbursts.

These two examples illustrate an approach to determining why children might persist in

Table 6-4. Changing the Environment

PROBLEM BEHAVIOR	POSSIBLE CAUSES	HOW TO CHANGE THE ENVIRONMENT
Running in the classroom.	Too much open space; room not divided into smaller areas.	Use shelves and furniture to divide the space.
Fighting over toys.	Few duplicate toys; children asked to share too often.	Provide duplicates of toys. Show children when it will be their turn (e.g., use a timer with a bell, a sand timer, or a list with names of children waiting for their turn).
Wandering around; unable to choose activities.	Room too cluttered; choices not clear; not enough to do.	Get rid of clutter. Simplify the layout of the room and materials. Add more activity choices.
Easily distracted; trouble staying with a task and completing it.	Areas undefined and open; children can see everything going on in the room.	Use shelves to define areas so children are not distracted by other activities.
Materials used roughly; resistance to clean-up.	Materials on shelves are messy; no order to display of materials.	Make a place for everything. Use picture labels to show where materials go.

exhibiting inappropriate behaviors that do not respond to Rules of Thumb approaches. **Functional analysis** is an "assessment" procedure that attempts to determine when, with whom, where, and under what conditions the behavior occurs. In other words, it is an attempt to answer the question: Why does the behavior occur? This approach attempts to determine the function of the behavior:

- Gain function. Is the child attempting to gain social attention, preferred activities, tangible items, or sensory stimuli?
- Escape/avoidance function. Is the child attempting to escape an unpleasant activity such as picking up toys? Is he trying to avoid too much noise or confusion in the environment?
- Unknown or intrinsic function. Is there something about the behavior itself that is reinforcing to the child?

The teacher must become a careful observer of environmental events that appear to maintain severe behavior problems, and she must test her hypotheses. This is a proactive approach in that the teacher will try to anticipate the inappropriate behavior and keep it from happening instead of reacting to a behavior that has already occurred. Knowing the function of a child's behavior brings us one step closer to developing a program that will teach the child a substitute behavior that is more appropriate and efficient in gaining what he or she wants or needs.

When it becomes necessary to treat certain behaviors in a more formal manner, the following steps can serve as guidelines.

Formal Behavior Treatment

The following pages will describe the procedures we have found most effective for managing inappropriate behavior needing a more formal treatment. Following the description of the procedures you will find an example of a behavior treatment program that illustrates a format for recording and communicating relevant information. The procedures are sequential and include 5 major steps.

STEP I: Pinpoint and Define

A vital first step in programming is to define the problem behavior precisely. All dimensions of the problem should be noted so that if one dimension changes, the teacher will be aware of it. For example, a tantrumming child might throw his toys and scream. Through treatment, it may be found that he continues to scream but no longer throws his toys. Or, he may continue screaming and throwing toys, but for shorter periods of time. Thus, when a teacher knows all the dimensions of a problem, he or she will be better equipped to measure the child's progress.

STEP II: Baselining

After the behavior has been defined, baseline data should be obtained. The baseline is a measurement of the parameters of the behavior prior to initiating specific treatment. Ideally, baseline data should be collected for 1 week, with a minimum of three observations. During the collection of baseline data, the behavior should be treated exactly as it was prior to initiating the baseline. In this way, baseline data will become a valuable tool with which to measure behavior change.

There are several ways to measure behavior, depending on how often the behavior is occurring, the availability of staff, and the type of behavior you wish to measure. In general, behaviors are measured with at least one of four methods:

- frequency
- duration
- percent
- interval recording

Frequency. Measuring frequency tells us how often a behavior occurs during a specified time period. For instance, a teacher may tally the number of times a child displays tantrums per day. Other behaviors that lend themselves to frequency counting include aggression, talking out, correct and incorrect responses, attendance, swearing, hand-raising and incidents of toy sharing. The advantage of using a frequency measure is that it can be used with a wide variety of classroom behaviors without disrupting the regular routine. However, if a behavior is occurring at a very high rate or lasts for an extended period of time, a frequency measure would generally be inappropriate. The following formula can be used to calculate the frequency of occurrence of a behavior:

$$\frac{\text{Total occurrences}}{\text{Total observation time}} = \text{Rate of occurrence}$$

$$\frac{\text{9 tantrums}}{\text{5 days}} = \text{1.28 tantrums per day}$$

Duration. Duration measures are used to determine the length of time a behavior is performed by an individual. Duration data may be collected for behaviors such as tantrumming, on-task behavior, time spent in cooperative play and other behaviors for which it would be helpful to know the number of seconds or minutes the behavior is observed. This method of measurement yields a precise record of the length of occurrence of a behavior, but requires the continuous attention of the observer and would generally be inappropriate for high-frequency behaviors of short duration. The following formula is used to calculate duration:

$$\frac{\text{Total length of occurrences}}{\text{Total number of occurrences}} = \text{Average length of each}$$

$$\frac{\text{36 minutes}}{\text{9 tantrums}} = \text{4 min. each}$$

Percentage reporting. Percentage reporting is a measurement of how often a behavior occurs compared to how often the behavior could possibly have occurred. This method has been used extensively to measure compliance. The formula is as follows:

$$\frac{\text{Total compliances}}{\text{Total opportunities to comply}} = \text{\% of compliance}$$

$$\frac{\text{22 compliances}}{\text{68 cues delivered}} = \text{32\% compliance}$$

Interval recording. The interval recording method involves dividing an observation session into equal periods of time and recording the occurrence or nonoccurrence of a behavior during these intervals. Interval recording can be of two types: continuous and time sampling. During continuous interval recording, the teacher's attention must be directed toward the behavior during the entire observation period, noting for each interval whether or not the behavior occurred. The observer must also have a method of timing each interval, such as a kitchen timer, stopwatch, or portable tape recorder with prerecorded interval counts.

Time sampling does not require the observer's continuous attention, because a data point is recorded only at the end of each interval. For example, attending behavior could be measured during a 20-minute period which is divided into 10 two-minute intervals. At the end of each 2-minute interval, the observer would look at the individual and record whether the individual was attending at that instant. This procedure would result in a percentage of intervals that the child was attending in relation to the total number of intervals observed. The teacher's records would be recorded as follows:

+ 0 + + 0 0 0 0 + +

The formula is as follows:

$$\frac{\text{Total occurrences}}{\text{Intervals}} = \text{\% of Total intervals}$$

$$\frac{5}{10} = 50\%$$

It is helpful at this point to place the behavior into one of the categories that were established during the previous discussion on rules of thumb (i.e., self-indulgence, aggression, self-stimulation, noncompliance). This will be immensely helpful in the process of determining the method of measurement.

Recommended measurement methods for categories of behavior:

- Self-indulgence -- measure the frequency and duration of the behavior.
- Non-compliance -- measure the number of compliances and non-compliances to obtain a percentage of compliance.
- Aggression -- measure frequency and/or duration of the behavior.
- Self-stimulation -- if the frequency of the behavior is low, measure frequency and duration. If the onset of the behavior is difficult to observe and the frequency is high, interval recording may be more reliable. If the behavior occurs across a number of environments, baseline data should be collected for each environment. Treatment may not generalize across environments and it may be necessary to design treatment for several environments.

Baseline data are computed at the completion of the baseline period using the appropriate formulas referred to previously. The summary of the baseline data should include the collection procedures used including the method of measurement, amount of time per day observed, and the location of the observations. A description of how the behavior was treated during the baseline period should also be summarized and kept with the data (see Figure 6-3 on page 76).

STEP III: Establishing A Terminal Objective

Once the baseline data are collected, you will have an accurate report of the frequency and severity of the behavior. Occasionally, the data will show that there is actually no need for a formal program. Usually, however, if there seems enough of a problem to warrant a baseline, you will probably find that a formal program will be necessary.

Look at the baseline data carefully. Do you see patterns concerning the severity of the behavior, the times of day at which it occurs, the activities with which it is associated? Use the baseline data and your knowledge of the child to help you to determine the most appropriate behavioral objective for the child.

Writing an appropriate objective that takes into consideration the child's needs is vital to the success of any behavior program. There will be times when a child can be expected to attain 100% success in eliminating a behavior; however, there will also be times when that goal will not be appropriate. For example, a child who exhibits a behavior at an exceptionally high frequency may not be able to achieve 100% success right away. Instead, you may want to work towards decreasing the behavior significantly. Once the child stabilizes at the reduced frequency, you can begin to work toward a new goal of 100% success. By working on the behavior in smaller increments, you can make change more attainable for the child. Another example concerns noncompliant behavior. It is not reasonable or even desirable to expect 100% compliance from anyone. (At the very most, a goal should be no higher than 80%) A compliance rate of 80% is quite acceptable.

When a formal program is being developed, every one with an interest in the child should be encouraged to give input. This might include the child's parents, classroom assistants, support staff, case manager, and other persons who are advocates for the child.

Once the goal is formulated, the objective should be written. The objective should be stated in positive language, and should be written in observable and measurable terms. By writing the objective in four parts, you will ensure that it meets these criteria:

1. Child's name (this helps to individualize the program)
2. State in observable, measurable terms what the child will be expected to do
   EXAMPLE: " ...will increase compliance to spontaneous cues..."
3. State the criteria
   EXAMPLE: "John will increase compliance to spontaneous cues to 80% compliance..."
4. State the length of time the child needs to maintain the behavior at criterion level.
   EXAMPLE: "John will increase compliance to spontaneous cues to 80% compliance for three consecutive weeks."

STEP IV: Designing a Treatment Program

Behavior programs should use natural social consequences in response to behaviors as much as possible. In many cases, this may be sufficient to bring the behavior under control. This approach is easy to conduct and introduces no artificial consequences which the teacher or parent may have difficulty accepting or implementing. Moreover, if the program is successful using social consequences, there will be no need to fade out the artificial consequences.

Treatment schematics (Tables 6-5 and 6-6) have been developed as general guidelines to aid in the development of a treatment program. Although not every problem will fit perfectly into the schematics, they should prove helpful in most cases. The schematics were developed through practical experience working with children and their families and reflect 20 years of experience. They are divided into two columns; one indicating the consequence for the desirable behavior and a second indicating the consequence for the inappropriate behavior. This procedure ensures that the child is always provided with an alternate desirable behavior rather than merely trying to eliminate one that is undesirable.

The schematics should be read horizontally, so that each treatment includes two consequences: one each for the desirable and undesirable behaviors. One pair of consequences should be used at a time. It is important to note that only one component (either the positive or negative consequence) changes with each successive treatment, and that the magnitude of the reinforcer is always

Table 6-5

TREATMENT FOR AGGRESSIVE BEHAVIOR

When the Behavior to be Increased Occurs, Do This:			When the Behavior to be Decreased Occurs, Do This:		
1.	Socially reinforce		1.	If behavior is mild, Ignore	If behavior is not mild, Time out
2.	Younger or Severely Handicapped Social reinforcer + Tangible reinforcer "A"	Older Tokens + Tangible reinforcer "A"	2.	Ignore	Time out
2a.	Social reinforcer + Tangible reinforcer "B"	Tokens + Tangible reinforcer "B"	2a.	Ignore	Time out
2b.	Social reinforcer + Tangible reinforcer "C"	Tokens + Tangible reinforcer "C"	2b.	Ignore	Time out
2c.	Social reinforcer + Tangible reinforcer "D" + Bonus	Token + bonus	2c.	Ignore	Time out
3.	Tangible reinforcer + Bonus	Tokens + bonus	3.	Time out	Alternative Punisher "A"
4.	Tangible reinforcer + Bonus	Tokens + bonus	4.	Alternative Punisher	Alternative Punisher "B"

TREATMENT FOR NON-COMPLIANT BEHAVIOR

When the Behavior to be Increased Occurs, Do This:			When the Behavior to be Decreased Occurs, Do This:	
1.	Socially reinforce		1.	Socially correct
2.	Younger or Severely Handicapped Social reinforcement + Tangible reinforcer "A"	Older Tokens + Tangible reinforcer "A"	2.	Socially correct
2a.	Social reinforcement + Tangible reinforcer "B"	Tokens + Tangible reinforcer "B"	2a.	Socially correct
2b.	Social reinforcement + Tangible reinforcer "C"	Tokens + Tangible reinforcer "C"	2b.	Socially correct
2c.	Social reinforcement + Tangible reinforcer "D"	Token + Tangible reinforcer "D"	2c.	Socially correct
3.	Tangible reinforcer + Bonus	Tokens & bonus	3.	Socially correct
4.	Tangible reinforcer + Bonus	Tokens & bonus	4.	Time out
5.	Tangible reinforcer + Bonus	Token & bonus	5.	Alternative punisher i.e., loss of privilege

Table 6-6

TREATMENT FOR SELF-STIMULATORY BEHAVIOR

	When the Behavior to be Increased Occurs, Do This:			When the Behavior to be Decreased Occurs, Do This:
	Younger or Severely Handicapped	Older		
1.	Socially reinforce		1.	Socially correct (plus restraint)
2.	Social reinforcer + Tangible reinforcer "A"	Tokens + Tangible reinforcer "A"	2.	Socially correct (plus restraint)
2a.	Social reinforcer + Tangible reinforcer "B"	Tokens + Tangible reinforcer "B"	2a.	Socially correct (plus restraint)
2b.	Social reinforcer + Tangible reinforcer "C"	Tokens + Tangible reinforcer "C"	2b.	Socially correct (plus restraint)
2c.	Social reinforcer + Tangible reinforcer "D"	Tokens + Tangible reinforcer "D"	2c.	Socially correct (plus restraint)
3.	Tangible reinforcer + Bonus	Tokens + bonus	3.	Socially correct (plus restraint)
4.	Tangible reinforcer + Bonus	Tokens + bonus	4.	Time out
5.	Tangible reinforcer + Bonus	Token + bonus	5.	Alternative punisher

TREATMENT FOR SELF-INDULGENT BEHAVIOR

	When the Behavior to be Increased Occurs, Do This:			When the Behavior to be Decreased Occurs, Do This:	
	Younger or Severely Handicapped	Older		When adult cannot ignore,	When adult can ignore,
1.	Socially reinforce		1.	Ignore	
2.	Social reinforcement	Tokens	2.	Time out	Ignore
2a.	Social reinforcement + Tangible reinforcer "A"	Tokens + Tangible reinforcer "A"	2a.	Time out	Ignore
2b.	Social reinforcement + Tangible reinforcer "B"	Tokens + Tangible reinforcer "B"	2b.	Time out	Ignore
2c.	Social reinforcement + Tangible reinforcer "C"	Tokens + Tangible reinforcer "C"	2c.	Time out	Ignore
3.	Tangible reinforcer + Bonus	Bonus system	3.	Time out	Ignore
4.	Tangible reinforcer + Bonus	Bonus system	4.	Time out	Time out
5.	Tangible reinforcer + Bonus	Bonus system	5.	Alternative punisher i.e., loss of privilege	Alternative punisher i.e., loss of privilege

increased prior to the introduction of a negative consequence. For example, a look at the schematics for noncompliance shows that treatment number one calls for social reinforcement for compliant behavior and social correction of noncompliance. If treatment number one is not successful, the second treatment would involve adding a tangible reinforcer to the positive social consequence. At this point, noncompliance continues to be socially corrected. The reinforcer is continually increased until treatment number four, when time out is implemented in place of social correction.

Determining a schedule for reinforcement often proves troublesome. Children exhibiting noncompliant behavior should initially be reinforced after each compliance. After the behavior reaches criterion level, however, the tangible reinforcers should be gradually faded out. It seems reasonable that the teacher would continue to give social reinforcement by saying "thank you" after each compliance. To determine the reinforcement schedule for aggression, self-indulgence and self-stimulation, divide the total amount of observation time by the number of occurrences. For example, if an individual displayed nine aggressions in 6 hours, the hours could be converted into minutes (6 hours x 60 minutes = 360 minutes) and divided by nine. This gives an average of one aggression every 40 minutes. Reinforcement should be delivered at one half of the average time between occurrence. Thus, if aggression is occurring once every 40 minutes, then a positive reinforcer should occur for every 20 minutes that the child displays appropriate behavior. After the individual meets success at this interval, the length of time between reinforcers may be gradually increased.

Although the schematics are intended for your use, it is important to remember that they should be individualized to each child. Thus, in the use of all reinforcers, you will want to choose items that are truly reinforcing to the child with whom you are working.

STEP V: Analyzing The Data

During the implementation of the treatment program, data are gathered daily. These data are analyzed weekly and are compared with the data of the previous week. If the data show an improvement over the previous week, the program continues unchanged. If the data show that the behavior has worsened over the past week, the teacher should first look at possible reasons for the trend. For example, it may be that the program needs to be changed; that either the reinforcer or the negative consequence needs to be changed. However, an analysis of 1 week's data might show that the behavior worsened after a change was made in the program. This "testing of the boundaries" usually occurs right after a change is made and lasts about 1 week. As the child realizes that the program is going to be run in a consistent manner, he or she begins to decrease the inappropriate behavior.

Data analysis is one of the most vital parts of the behavior management process. Without it, data are collected for no usable reason, and behavior change--if it happens at all--is haphazard and left mostly to chance. Data analysis leads directly to clear choices about program modification.

STEP VI: Modification of the Program

This entire process of analyzing data is based upon comparing the current week's data with that of the previous week. If the data do not show improvement and do not fall into one of the exceptions previously described, then the program should be changed.

When the program is to be changed, the general rule is to increase the power of the positive reinforcer, leaving the negative constant until all of the positive have been explored. Generally, reinforcers will be sufficient to modify the behavior without ever having to impose a negative stronger than social correction. However, when positive approaches have been shown to fail to reduce the problem behavior, it may become necessary to implement a stronger negative. The actual procedure selected should be based on the individual characteristics of the child and the behavior, the ability of staff to carry out the program in a consistent manner, and the probability of successfully eliminating the behavior by implementing the procedure.

By systematically making changes in the program, the teacher will usually be able to help a child improve his or her behavior. The usefulness of formal behavior treatment lies, however, in the consistency of its implementation. If a teacher chooses to implement a program, it should be used by all staff throughout the day, and the data analysis and program modification should occur on a regular basis.

STEP VII: Maintaining Behavior Change

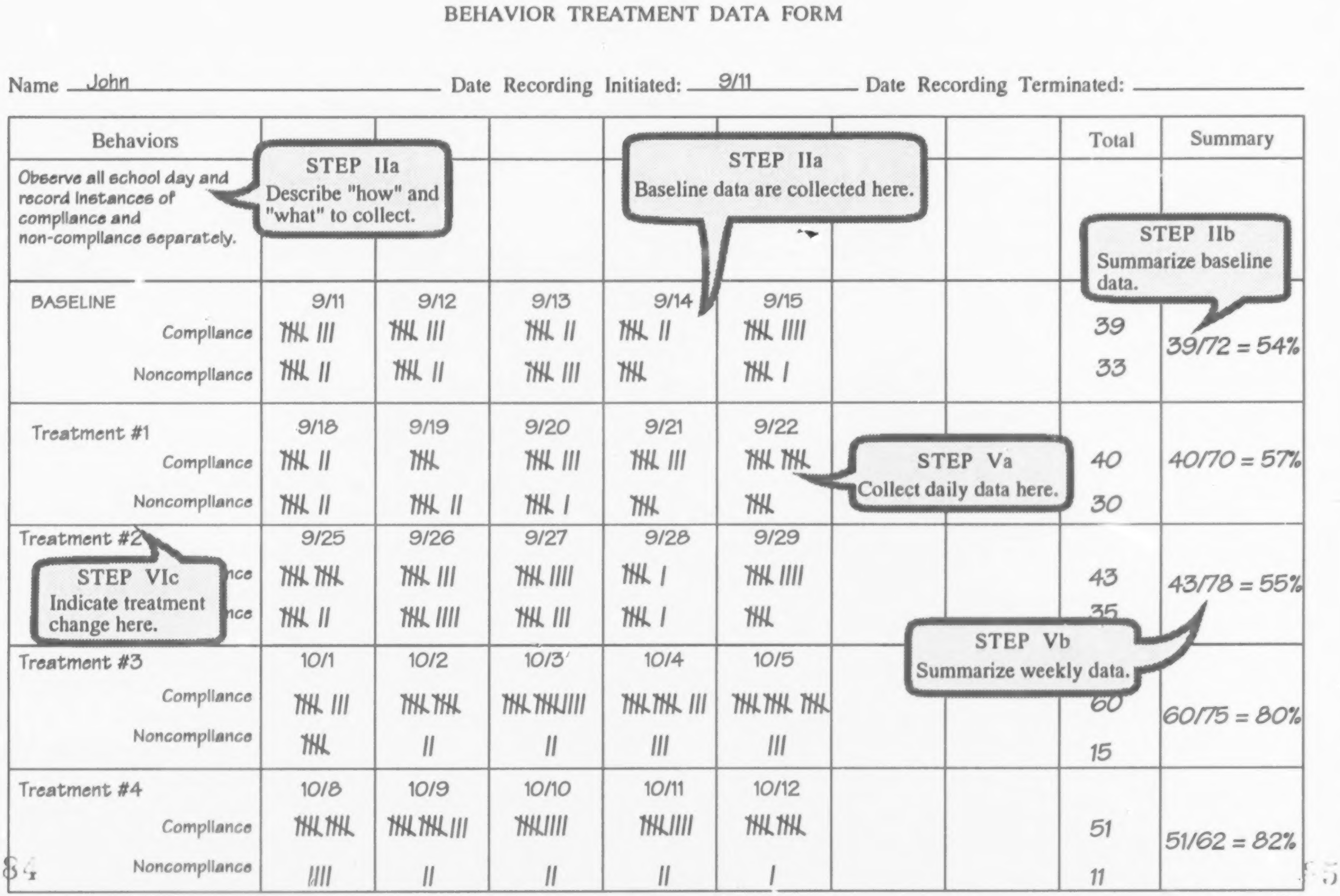
After the objective for the program is achieved and all artificial reinforcers have been faded, the program is finished. At this point, the child should be responding to the natural consequences of the environment. At a later time, if the behavior should reoccur on a consistent basis, a new program might need to be developed; however, if your behavior program was conducted consistently and appropriately, there will rarely be a need to rework an old behavior program.

FORMAL BEHAVIOR PROGRAM EXAMPLE FORMAT

The following pages illustrate the step by step procedures for developing a formal behavior treatment program through a sample program using Teaching Research forms (see Table 6-7). Each step of the procedure can be referenced to the sample program. The reader may find these forms helpful for designing programs in the future.

Table 6-7

STEP	PROCEDURE	RELATED FORM
I	Pinpointing and defining the behavior	N/A
II	Baselining the behavior	
	A. Collect baseline data	Behavior Treatment Data Form (Figure 6-2)
	B. Summarize baseline data	Behavior Program Cover Sheet (Figure 6-3)
III	Establish a program objective	Behavior Program Cover Sheet (Figure 6-3)
IV	Design a treatment program	Behavior Program Treatment Form (Figure 6-4)
V	Analyzing Data	
	A. Collect daily data	Behavior Treatment Data Form (Figure 6-2)
	B. Summaries data weekly	Behavior Treatment Data Form (Figure 6-2) Behavior Program Cover Sheet (Figure 6-3)
VI	Modify Program	
	A. Compare each week's data to prior weeks and baseline data	Behavior Program Cover Sheet (Figure 6-3)
	B. Modify treatment as necessary	Behavior Program Treatment Form (Figure 6-4)
	C. Indicate treatment changes on data forms	Behavior Treatment Data Form (Figure 6-2) Behavior Program Cover Sheet (Figure 6-3)
VII	Maintenance of behavior change	
	A. Fade exaggerated reinforcers and/or punishers	Behavior Program Treatment Form (Figure 6-4)
	B. Collect maintenance data	Behavior Treatment Data Form (Figure 6-2) Behavior Program Cover Sheet (Figure 6-3)



BEHAVIOR TREATMENT DATA FORM

Name John Date Recording Initiated: 9/11 Date Recording Terminated:

Behaviors								Total	Summary
Observe all school day and record instances of compliance and non-compliance separately.									
BASELINE	9/11	9/12	9/13	9/14	9/15				
Compliance	𝍸 III	𝍸 III	𝍸 II	𝍸 II	𝍸 IIII			39	39/72 = 54%
Noncompliance	𝍸 II	𝍸 II	𝍸 III	𝍸	𝍸 I			33	
Treatment #1	9/18	9/19	9/20	9/21	9/22				
Compliance	𝍸 II	𝍸	𝍸 III	𝍸 III	𝍸 𝍸			40	40/70 = 57%
Noncompliance	𝍸 II	𝍸 II	𝍸 I	𝍸	𝍸			30	
Treatment #2	9/25	9/26	9/27	9/28	9/29				
nce	𝍸 𝍸	𝍸 III	𝍸 IIII	𝍸 I	𝍸 IIII			43	43/78 = 55%
nce	𝍸 II	𝍸 IIII	𝍸 III	𝍸 I	𝍸			35	
Treatment #3	10/1	10/2	10/3	10/4	10/5				
Compliance	𝍸 III	𝍸 𝍸	𝍸 𝍸 IIII	𝍸 𝍸 III	𝍸 𝍸 𝍸			60	60/75 = 80%
Noncompliance	𝍸	II	II	III	III			15	
Treatment #4	10/8	10/9	10/10	10/11	10/12				
Compliance	𝍸 𝍸	𝍸 𝍸 III	𝍸 IIII	𝍸 IIII	𝍸 𝍸			51	51/62 = 82%
Noncompliance	IIII	II	II	II	I			11	

STEP IIa
Describe "how" and "what" to collect.

STEP IIa
Baseline data are collected here.

STEP IIb
Summarize baseline data.

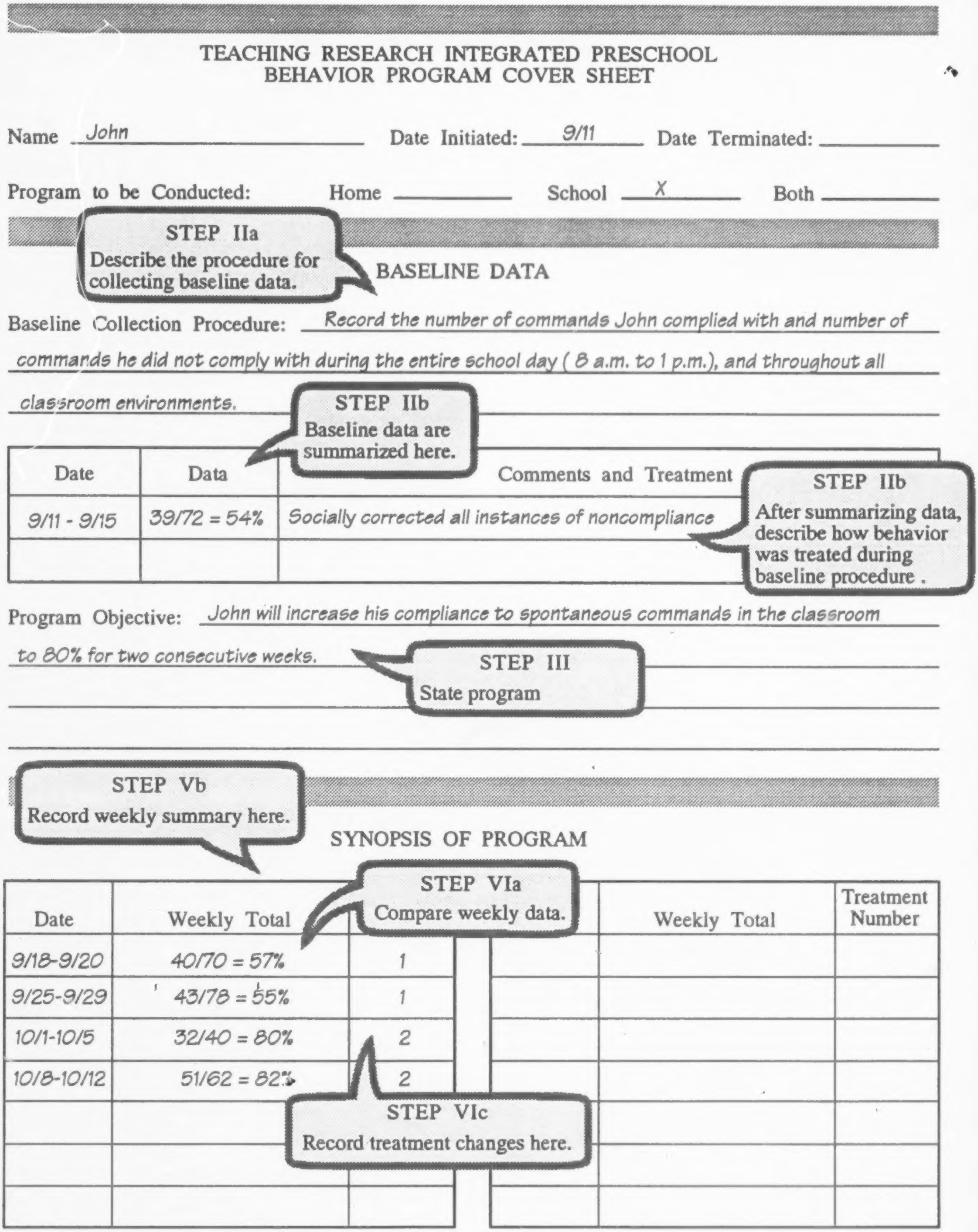
STEP Va
Collect daily data here.

STEP VIc
Indicate treatment change here.

STEP Vb
Summarize weekly data.

F6-2

Figure 6-2. Behavior Treatment Data Form



TEACHING RESEARCH INTEGRATED PRESCHOOL
BEHAVIOR PROGRAM COVER SHEET

Name John Date Initiated: 9/11 Date Terminated: ________

Program to be Conducted: Home ________ School X Both ________

STEP IIa
Describe the procedure for collecting baseline data.

BASELINE DATA

Baseline Collection Procedure: Record the number of commands John complied with and number of commands he did not comply with during the entire school day (8 a.m. to 1 p.m.), and throughout all classroom environments.

STEP IIb
Baseline data are summarized here.

Date	Data	Comments and Treatment
9/11 - 9/15	39/72 = 54%	Socially corrected all instances of noncompliance

STEP IIb
After summarizing data, describe how behavior was treated during baseline procedure .

Program Objective: John will increase his compliance to spontaneous commands in the classroom to 80% for two consecutive weeks.

STEP III
State program

STEP Vb
Record weekly summary here.

SYNOPSIS OF PROGRAM

STEP VIa
Compare weekly data.

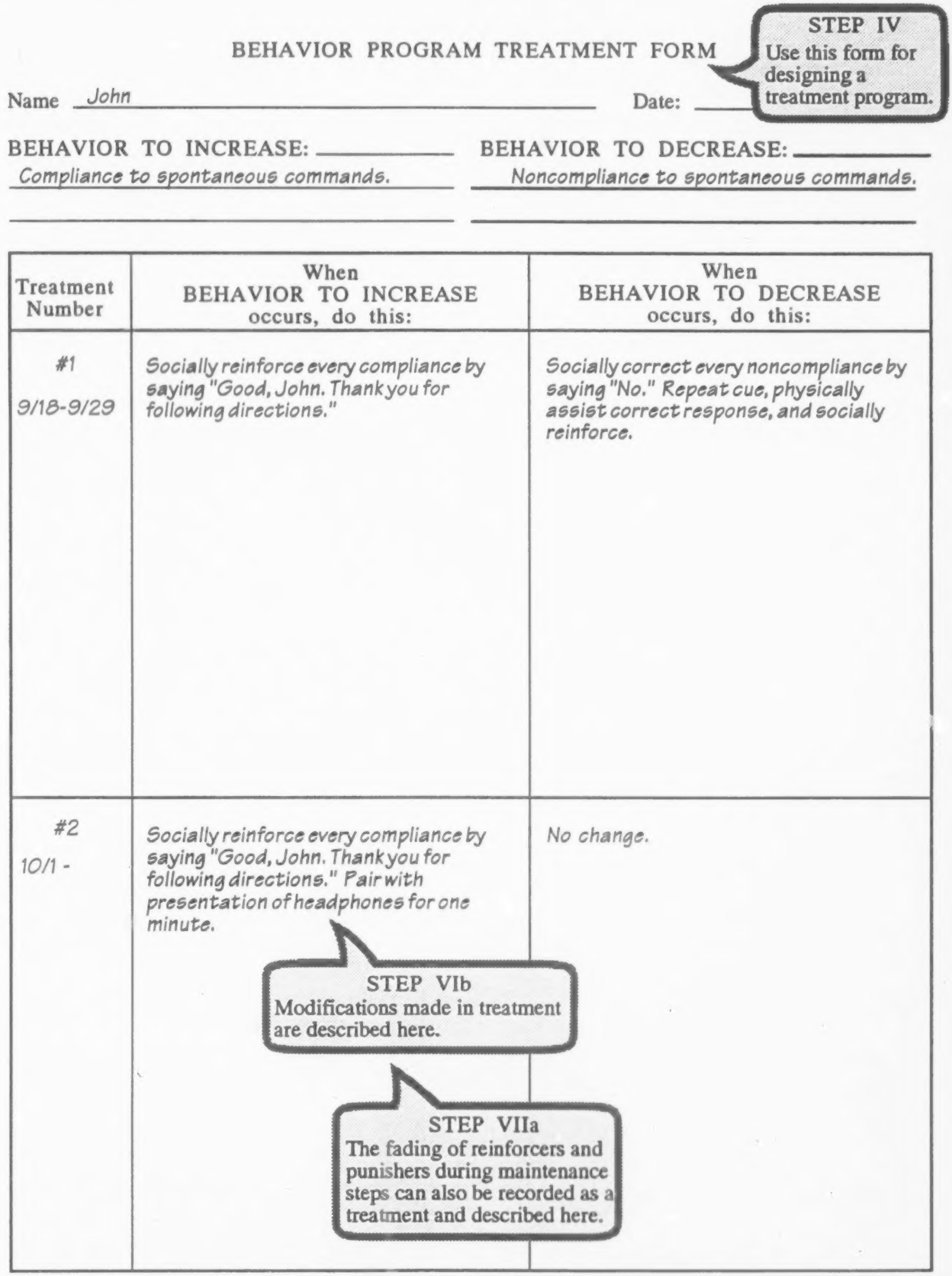
Date	Weekly Total			Weekly Total	Treatment Number
9/18-9/20	40/70 = 57%	1			
9/25-9/29	43/78 = 55%	1			
10/1-10/5	32/40 = 80%	2			
10/8-10/12	51/62 = 82%	2			

STEP VIc
Record treatment changes here.

F6-3

Figure 6-3. Behavior Program Cover Sheet

86



BEHAVIOR PROGRAM TREATMENT FORM

Name *John*

Date:

BEHAVIOR TO INCREASE: *Compliance to spontaneous commands.*

BEHAVIOR TO DECREASE: *Noncompliance to spontaneous commands.*

Treatment Number	When BEHAVIOR TO INCREASE occurs, do this:	When BEHAVIOR TO DECREASE occurs, do this:
#1 *9/18-9/29*	*Socially reinforce every compliance by saying "Good, John. Thank you for following directions."*	*Socially correct every noncompliance by saying "No." Repeat cue, physically assist correct response, and socially reinforce.*
#2 *10/1 -*	*Socially reinforce every compliance by saying "Good, John. Thank you for following directions." Pair with presentation of headphones for one minute.*	*No change.*

STEP IV
Use this form for designing a treatment program.

STEP VIb
Modifications made in treatment are described here.

STEP VIIa
The fading of reinforcers and punishers during maintenance steps can also be recorded as a treatment and described here.

F6-4

Figure 6-4. Behavior Program Treatment Form

Summary of the Procedure

The preceding approach for managing undesirable behavior has proven highly successful and usable by numerous teachers. It is important to note that it is the process that is being recommended. Whether or not the reader adopts the 3 page behavior program format designed by Teaching Research or utilizes an alternative form for recording relevant program information, the process should proceed according to the 7 steps outlined.

Summary

Developing social competence should be a primary goal for young children. Social competence is a web of interrelated social skills and skills from all areas of development. Skills such as acquiring a desired toy, resolving conflicts, following rules and routines, and gaining entry to a peer group are needed for a child to gain peer and adult acceptance. Promoting social competence of children with disabilities is a difficult challenge. This chapter has described strategies for facilitating the development social skills. The placement of children with disabilities in settings with same age peers is a primary strategy.

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Chapter Seven

TRAINING AND SUPPORT FOR STAFF

Joyce Peters, Tom Udell, Lisa Carlson, Gary Glasenapp

There is much room for improvement in education concerning recognition of the importance of, and support for, systematic staff development for professional and paraprofessional workers. Special education has done a somewhat better job in this endeavor because staff development has been stimulated, in large part, by mandatory Federal legislation. States set aside monies to provide staff training and the need for ongoing needs assessment, and training for practitioners has been commonly recognized.

Along with the movement toward keeping children with disabilities in their homes and communities comes an ever-expanding challenge to meet a wide range of children's needs. Teacher training programs provide a base, but ongoing staff development continues to be the best way for meeting the changing needs of children and families. Certainly there are new demands for both training and support for early intervention specialists and preschool/child care staff serving young children.

With the commitment to serve all children in community programs comes the responsibility for training and support of staff in those programs. With the shift toward community integration of these children is the emergence of a new staff role, that is, early intervention specialist, early intervention consultant, itinerant teacher, itinerant specialist, or support aide.

In an integrated preschool program, we see two sets of people working together to serve and support the child: professionally trained special education personnel and community preschool/child care staff.

Professionally trained special education personnel would include teachers, therapists (physical, occupational, speech) and specialists (mobility, vision, hearing, etc.). Their responsibilities generally include assessment, development of IFSP goals with parents and other relevant professionals, development of instructional plans for children with special needs, monitoring progress, and training/-supporting community staff.

People who comprise the staff in community preschool/child care settings would include center directors, teachers, teaching assistants, student/parent volunteers, and a special education support aide in cases where the child's disabilities or needs warrant this level of support. These people deliver the day-to-day, direct services to children and their families. One might think of the two bodies of personnel needed to provide quality services to young children with disabilities as two teams each bringing their diverse expertise to bear on the same target, the child and his family. This dual relationship is illustrated in Figure 7-1.

The focus of training and support activities for individuals working directly with children who have special needs can best be viewed as a two-pronged effort: (a) core training to enable staff to enhance the setting for **all** children; and (b) specialized training to serve a particular child with disabilities.

The special education professional must view the general level of core training as an integral part of his or her responsibility. The majority of communities offer a limited number of community programs to select from, which heightens the responsibility of the professional team to enhance the quality of

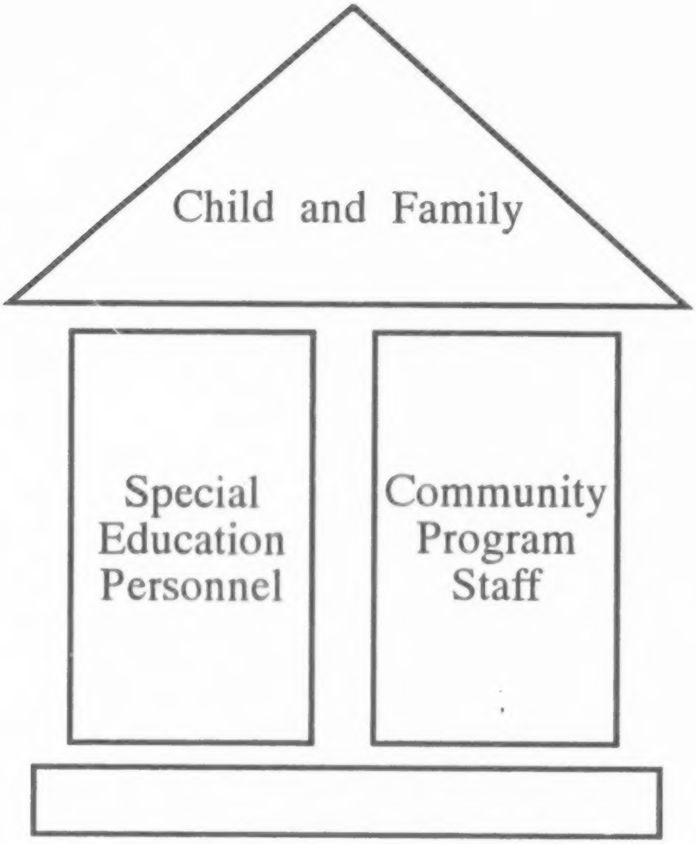


Figure 7-1. Support Team for the Child and Family

these programs prior to placement of a child with special needs. Many community early childhood programs have very limited resources with which to provide staff development opportunities, making the contributions of the special education professional all the more valuable to the program as a whole. In exceptional situations, a given community may have a rich reservoir of programs to choose from in placing a child with disabilities, and the special education professional and family would have the luxury of selecting a site with a strong early childhood base that reflects developmentally appropriate practices.

The first step in developing a general early childhood training package is to pinpoint the target audience and determine the training needs. This can be easily accomplished through a survey, questionnaire, or observation. This method of information gathering is called needs assessment.

Needs assessment typically employs questionnaires, surveys, self-assessment, or interviews in order to determine the opinions, attitudes, preferences, and perceptions of persons targeted for inservice training. For the purpose of identifying training topics, a Likert Scale survey can be used to determine the preschool/child care personnel's perceived need for information on specific topics, or their perceived level of competence relative to teaching children with disabilities. Surveys are most appropriate for determining the general training needs of a large group of individuals.

The following example illustrates a needs assessment that was used to identify training topics for child care providers in Oregon and parts of Colorado, Washington, and New Mexico (Figure 7-2). Topical headings included information on child development, handicapping conditions, social interaction and play, language and communication, working with parents, and behavior management. The survey also included some open-ended questions regarding advantages and disadvantages to teaching children with disabilities within integrated environments, as well as questions directly requesting topics of interest for training. The results of this survey showed interest and need for training information regarding handicapping conditions and working with parents. This is illustrated in Figure 7-3.

The Accreditation Criteria and Procedures of the National Academy of Early Childhood Programs (NAEYC) provides another effective vehicle for defining training objectives. This instrument is a self-assessment tool which enables child care centers to pinpoint areas of strength and weakness. This information can then be used to identify training needs.

Another form of needs assessment involves direct observation. Observation is frequently used to validate topics identified through a survey or self-assessment, it can also assist in pinpointing specific topic areas. While surveys are useful for identifying general training needs, observation can assist in narrowing the topics into manageable training subjects.

Several instruments have been successfully utilized in identifying specific staff training needs in child care centers. The Early Childhood Environmental Rating Scale (ECERS) (Harms and Clifford, 1980) can be used to identify specific areas of strength and weakness for a given child care center and can suggest subsequent training topics. The ECERS consists of 37 items each that are scored on a scale from 1 to 7. The items are clustered together into one of seven areas: personal care routines, furnishings and display, language-reasoning experiences, gross-motor activities, creative activities, social development, and adult needs. A profile of strengths and weaknesses results from the observation. This information can then be quantified and developed into training topics and objectives.

The outcome of the above-mentioned needs assessments will yield a set of general skills needed to enhance the overall quality of a community preschool/child care program for all children and a set of specific skills needed by staff to appropriately meet the needs of children with disabilities.

Content of Training for Community Program Staff

Although there are numerous approaches to determining both general and specific staff training needs, there appear to be common and predictable needs. Typical concerns related to improving or enhancing the community preschool/child care setting in general would include the following core training needs which are not necessarily listed in a priority order: (a) healthy, safe environments, (b) early childhood curricula, (c) early childhood instructional strategies, (d) environmental arrangement, (e) normal child development, (f) child guidance strategies, and (g) staffing.

The areas related to preparing staff to serve children with disabilities commonly include issues such as: (a) special education terminology, (b) disabilities, (c) group participation, (d) instructional strategies, (e) family involvement, (f) social/behavior management, (g) working with support specialists, and (h) monitoring progress toward IFSP goals. The most commonly stated needs are summarized in Tables 7-1 and 7-2.

Formats for Delivering Staff Training

The mechanisms by which staff training is delivered are dictated by the resources, support, and leadership available to a program. There appears to be great diversity in staff training resources among early childhood programs. This diversity reflects the current absence of consistent standards for

Project TRAC - Teaching Research Training And Assistance to Child Care Providers Serving Young Children With Special Needs[1]

NEEDS ASSESSMENT

This questionnaire asks about the training you would like to have in order to serve children with special needs in your classroom. Your answers will be confidential.

Program Name: ______________________________ Job Title: ____________________

Needs for Information

This section asks about the information you feel you need to serve children with special needs. Please rate each item using the following scale (from 1 = I do not need information to 3 = I need a lot of information). Write your answer next to each statement.

1 = I do not need information about this
2 = I need some information about this
3 = I need a lot of information about this

Information About Child Development

____ 1. I need more information about normal child development.
____ 2. I need more information about how speech and language skills develop in young children.
____ 3. I need more information about how play skills develop in young children.
____ 4. I need more information about social and emotional development in young children.
____ 5. Other (please specify) ____

Information About Handicapping Conditions

____ 1. I need more information about different handicaps.
____ 2. I need more information about unusual patterns of child development.
____ 3. I need more information about how to help children with handicaps.
____ 4. I need more information about special education services such as occupational, physical, and speech therapies.
____ 5. I need more information about the reasons for mainstreaming children with handicaps.
____ 6. I need more information about how to talk with parents and children about handicapping conditions.
____ 7. I need more information about health and safety issues which may exist when a child with handicaps attends my classroom.
____ 8. Other (please specify) ____

Information About Social Interaction and Play

____ 1. I need more information about how to arrange my classroom so that children will want to play with each other.
____ 2. I need more information about how to balance group activities and individual instruction in my classroom.
____ 3. I need more information about how to help children who are at different developmental levels learn to play together.

[1] This survey was developed by the George Washington University, School of Education and Human Development, Department of Teacher Preparation and Special Education. Project Bridging the Gap, (1990).

Figure 7-2. Example of Assessment Instrument for Determining Training Needs

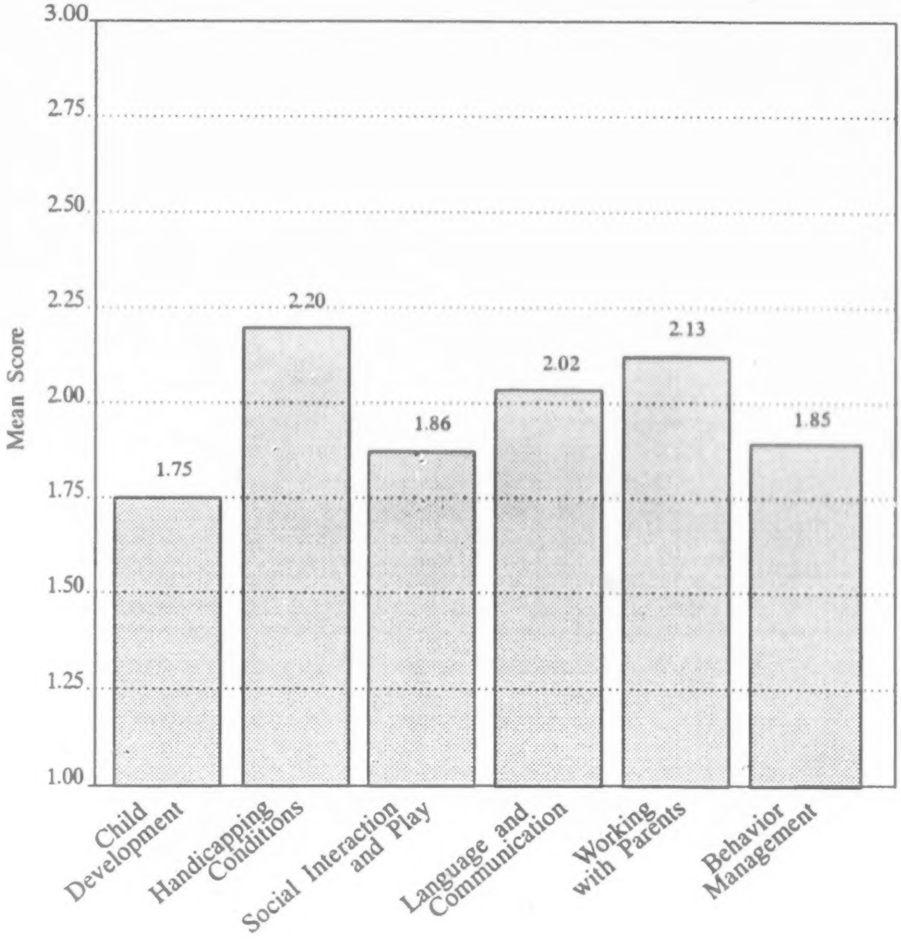


Figure 7-3. Results of Training Needs Assessment

early childhood certification in half the states. Consequently, there is a shortage of well-qualified early childhood teachers to meet current needs, much less anticipated future demands. Many small, home care or facility-based programs have no reserves to cover costs for training staff including substitutes. Many of these small programs employ staff on an hourly basis and staff members have no opportunity during the work day to meet together.

The great diversity of available resources to support staff development activities dictates a need for flexibility in how such training is structured. Possible formats may include (a) regular staff meetings, (b) workshops, (c) teacher exchange, (d) review of written material, (e) review of audio/video material, and (f) ongoing technical assistance. Table 7-3 summarizes these formats.

Training Staff to Deliver Instruction to Children

Staff members who serve children with disabilities in community preschool centers require specialized training in addition to the core competencies or skills that will enhance the learning environment for all the children in the center. In this setting, special education professionals may be responsible for training

Table 7-1. Core Training Needs

Health, Safety, Nutrition	Many early childhood community programs need assistance to interpret, implement, and monitor guidelines established by licensing or certifying boards. The specific topical areas will be dictated by the physical facilities available in each site, but frequently information on universal health precautions provided by a health professional is called for. Procedures used by staff for changing diapers, cleaning changing areas, cleaning eating areas, food selection and preparation, and handling bodily fluids are frequently topics for training.
Early Childhood Curricula	Development of quality early childhood curricula appears to be an ongoing need in most programs. NAEYC guidelines provide the standard by which programs should plan environments and activities appropriate for young children. Developmentally appropriate curricula provide for all areas of development and approach learning as an interactive process. Curricula are based on knowledge of each child's interest, experiences, and developmental progress as well as a broad understanding of what is appropriate for the age span of the group. Community preschool/child care staff often need additional training in recognizing and planning age-appropriate activities, understanding learning as an interactive process, recognizing/planning for cultural diversity, and developing children's self-esteem.
Early Childhood Instructional Strategies	Instruction in a developmentally appropriate early childhood setting is driven by children's active exploration of environments that provide concrete learning activities with materials relevant to their own experiences. While participating within a small group, children are encouraged to select activities they are interested in. The teacher's focus should be on the process of involvement rather than the outcome or product of a given activity. Within this framework, teachers often need training in preparing the learning environment and in facilitating children's involvement within the environment.
Environmental Arrangement	The quality of a child's experience in an early childhood program is dependent in large part on the attention that staff pay to the arrangement of furniture and other learning materials within the environment. Young children benefit from settings that provide a variety of interest centers including quiet areas for one or two children, areas for gross-motor activities, blocks, and dramatic play or dress-up areas. Quality community programs also provide opportunities for creative expression (art and music) and quiet, comfortable spaces for curling up to rest.
Normal Child Development	Regardless of their role, work setting, or the age of children served, early childhood professionals must have knowledge of the sequence of normal development and the interrelationship of different areas of development, i.e., social, cognitive, language, physical. They must be thoroughly grounded in their understanding of biological and environmental factors influencing normal development and characteristics of children with special needs that result from familial, social, or cultural factors. In order to carry out their work, early childhood program staff may need inservice opportunities to increase their knowledge of normal development and gain practice in observation and application of theoretical information in the classroom setting.
Child Guidance Strategies	One of the most persistent challenges facing adults working with young children is that of appropriate guidance and management strategies for inappropriate, but typical, child behaviors such as whining, hitting, biting, and refusal to meet requests. Whether one is working in a home care setting with a few children or in a center-based program with a large number of children; staff consistently indicate the need for information and training related to appropriate and consistent adult management strategies.
Staffing	High adult-to-child ratios is widely excepted as an indicator of high quality early childhood programs. Ratios as high as one adult to every four children is advocated by many professionals; however, few community preschool/child care programs can financially support the amount of staff need to achieve this. Because of this, most providers need training in effectively recruiting, training, and managing volunteers.

Table 7-2. Training Needs for Serving Children with Disabilities

Special Education Terminology	As with many professions, special educators have terminology and jargon which may be unfamiliar to many child care personnel. Early childhood educators have expressed a need for clarification of the diverse range of technical terminology used in special education. This may involve terminology which relates to diagnostic information, legal issues, data collection, instructional strategies, and curricula.
Disabilities	In order to successfully develop educational programs for individual children with disabilities, it is essential that the special educator and the child care professional have access to information about a variety of handicapping conditions. Although it is well established that children with disabilities are more like their nondisabled peers than they are different, there may be specific information that relates to their disability which could be beneficial in developing and implementing a successful educational program. Community-based early childhood programs typically request information on children with motor impairments, hearing and visual problems, seizure disorders, severe emotional/behavior problems, and severe cognitive delays.
Group Participation	Many community child care programs may need assistance in learning strategies for successfully integrating children with disabilities into small- and large-group activities. Specifically, we have found that child care providers wanted information on how to adapt activities and materials and how to help children who are at different developmental levels learn to play together.
Instructional Strategies	Additional training in instructional strategies for children with disabilities is often needed by the staff of community child care programs. Direct, activity-based instruction including data collection and analysis are not typically familiar to early childhood professionals in the field.
Family Involvement	Although the importance of family involvement in the lives of young children has been well established, some community-based child care programs may need assistance in developing strategies for interacting with parents who have a child with a disability. Many child care programs have established a variety of methods for communicating and interacting with parents. However, families with a child who has a disability may not be responsive to the traditional methods of communication. Some specific topical areas for discussion with a child care provider might include the grief cycle parents may go through upon learning of their child's disability, how and when to refer a family for professional help, and strategies for helping families better understand their children's developmental needs.
Social/Behavior Management	Behavior management issues arise frequently in community child care programs. Information on methods for preventing behavior problems in the classroom appears to a recurrent theme. A subsequent topic which goes hand in hand with behavior management is the need for strategies for increasing opportunities for positive social interactions.
Support Specialists	Community child care programs frequently need clarification on the role and responsibilities of the support specialists who may be involved with a particular child. These support specialists may include physical, occupational, or speech therapists, health professionals, vision or hearing specialists, and others. Child care providers may need to learn a variety of strategies for incorporating prescriptive motor, language, behavior, or health programs into the flow of their regularly occurring activities.
Monitoring Student Progress	Data collection is frequently a cause of concern and anxiety for many community child care programs. Most early childhood educators have had little exposure to the variety of systems available for monitoring student progress toward their educational goals and objectives. Furthermore, they frequently need basic information on why data are collected and what they are used for. Once this foundation has been established, additional information and discussion can be generated on what type of data collection system would best suit the child care program and individual child.

Table 7-3. Formats for Delivering Staff Training

Regular Staff Meetings	Regularly scheduled staff meetings are needed for staff to consult on and discuss program planning issues, the needs of individual children, and other program concerns. These meetings can serve as an informal assessment of training needs as well as a forum for brief but focused information on specific topics. Training can also be accomplished through staff sharing information and resources gathered from outside workshops or from independent review of written materials.
Workshops	Numerous workshops are available within states and nationally that are relevant to practitioners in the early childhood/special education field. Many workshops are designed to meet a particular need of a program or group of programs. For example, two child care centers in the same community could invite a health care professional to speak on infectious diseases. When selecting workshops, one must consider how the presenter's outcomes align with the program's goals for staff development. There are basically three types of outcomes: increased awareness, increased knowledge, and skill acquisition. Workshops that provide awareness and knowledge are general in nature and focus on basic concepts and general information. These types of workshops will have minimal impact on day-to-day program operation. Skill training goes beyond awareness and knowledge training and allows the participant hands-on activities in order to develop competency. This type of training will have the greatest impact on day-to-day performance.
Teacher Exchange	Experiencing the implementation of techniques and strategies first hand and in a setting similar to one's own can be a powerful training tool. This can be done through a teacher-exchange program in which a staff person receives training by becoming an active part of the staff at a program using techniques that would enhance professional development. Ideally this would be an exchange of staff between programs, thus becoming a mutual sharing of program strengths.
Review of Written Material	One cost-effective way of providing awareness and knowledge level training is through the dissemination of written material to staff. Although retention of written information is relatively low, providing time for staff discussion of commonly reviewed material or assisting staff to present information individually to the remainder of the staff can boost retention and proves beneficial to the entire program.
Review of Audio/Video Material	There are many good early childhood and early childhood special education audio and video presentations on the market, many of which can be rented. Accessing these as a resource can provide cost-effective training with the time flexibility needed by most early childhood programs. As with written information, providing time for discussion and sharing of information can boost retention.
On-Site Technical Assistance	Providing ongoing technical assistance as part of the working environment is one of the most effective training approaches that can be incorporated into a staff development program. It allows for the shaping of behavior over time and can incorporate immediate practice. The following section describes a recommended approach to training that includes ongoing technical assistance.

staff members in the skills necessary to work effectively with students with disabilities. The specific training needs of the classroom staff are determined as the result of a needs assessment. Many of the common needs and issues that have been identified for classroom staff through the assessment process were overviewed earlier in this chapter. Providing staff members with the skills necessary to deliver instruction to children is a high priority for most centers. This section discusses the approach utilized by the TRIP model to provide initial and ongoing training and technical assistance to staff members who deliver instruction to children in an integrated community preschool/child care program.

In the midst of paper work, children's needs, parent conferences, IFSP meetings, and other tasks that a teacher is expected to perform, finding time for training of staff may seem like one more burden. We do know, however, that time taken to train staff will result in a more efficient and effective program. Staff training and technical assistance is seen as a process that continues throughout the year. While initial training efforts that take place when a person first begins working with children are important, it is vital that training is viewed as a neverending process with the training needs changing or becoming more refined as the staff members incorporate skills into their daily routines and responsibilities.

The outcome of ongoing training efforts should be to provide the staff with the skills necessary to deliver appropriate instruction to all children in the program. To accomplish this, a variety of activities are utilized. The TRIP model approach includes an orientation session, opportunity to observe the staff as they demonstrate the skills and techniques described, supported experience to practice the skills with children in the classroom or in a role-play situation, and an opportunity to receive precise feedback regarding their performance in the practica setting. Each of these items is described in more detail below.

Orientation

Orientation is the first step in the training process. This session consists of both explanation and demonstration. At this time the teacher may also want to give the new staff copies of pertinent information regarding the program such as classroom descriptions, information on disabilities and emergency medical information and procedures. Some points that the teacher might want to cover during the initial orientation include the following:

- A description of activity-based instruction and how the activity centers work
- An overview of the clipboard format
- Using appropriate cuing methods
- Using appropriate positive reinforcement and the correction procedure
- Strategies and techniques to facilitate indirect language stimulation
- Dealing with problem behaviors through the use of rules of thumb
- A description of the record keeping system (data collection)

As part of the orientation, the teacher may incorporate a variety of activities to present the needed information. These might include the use of video tapes, role playing and modeling.

Because the vast majority of skills are taught to children with disabilities in the natural setting in a group situation, the teacher will probably spend the majority of time training skills that will be used in this setting and format. In training staff to facilitate learning at the activity centers, the teacher's goal is to develop four basic skills: (a) the delivery of appropriate cues, (b) the use of appropriate consequences, (c) the proper use of indirect language stimulation techniques, and (d) the recording of responses for children with disabilities. What follows is a description of how the teacher can train staff in skills that are needed when working with children in an activity based, group setting.

Observation

After the orientation session, the next step of the training process involves observing in the classroom. As part of the observation, the teacher or staff can demonstrate or model appropriate techniques with the children while the trainee observes. This gives the trainee an opportunity to see how the skills should be used and to ask any questions that may arise.

Practice

After the trainee has had the opportunity to observe the staff model or demonstrate the skill with children, the trainee next has a chance to practice the skill either in a role-play situation or with the children in the classroom. As the trainee practices, the teacher will watch, using an observation form. Figure 7-4 shows the Group Observation Form. This form is used by the teacher so that he or she can provide the trainee with specific performance feedback. An explanation on how to use the form follows.

The Group Observation consists of a 10-minute observation period (five 2-minute segments). Marks are made in 2-minute time intervals. Therefore, all the marks in the first 2 minutes are made in the first row of boxes across the page, the next 2 minutes in the second row of boxes, and so on.

An explanation of each of the column headings on the observation form follows:

Actively supervises and rotates attention. Person gives attention to or has some type of interaction with all children present at learning center at least once during each 2-minute time segment.

Indirect language stimulations. A tally mark is made each time the person uses an indirect language stimulation technique such as describing what the child is doing or expanding on what the child has said or done.

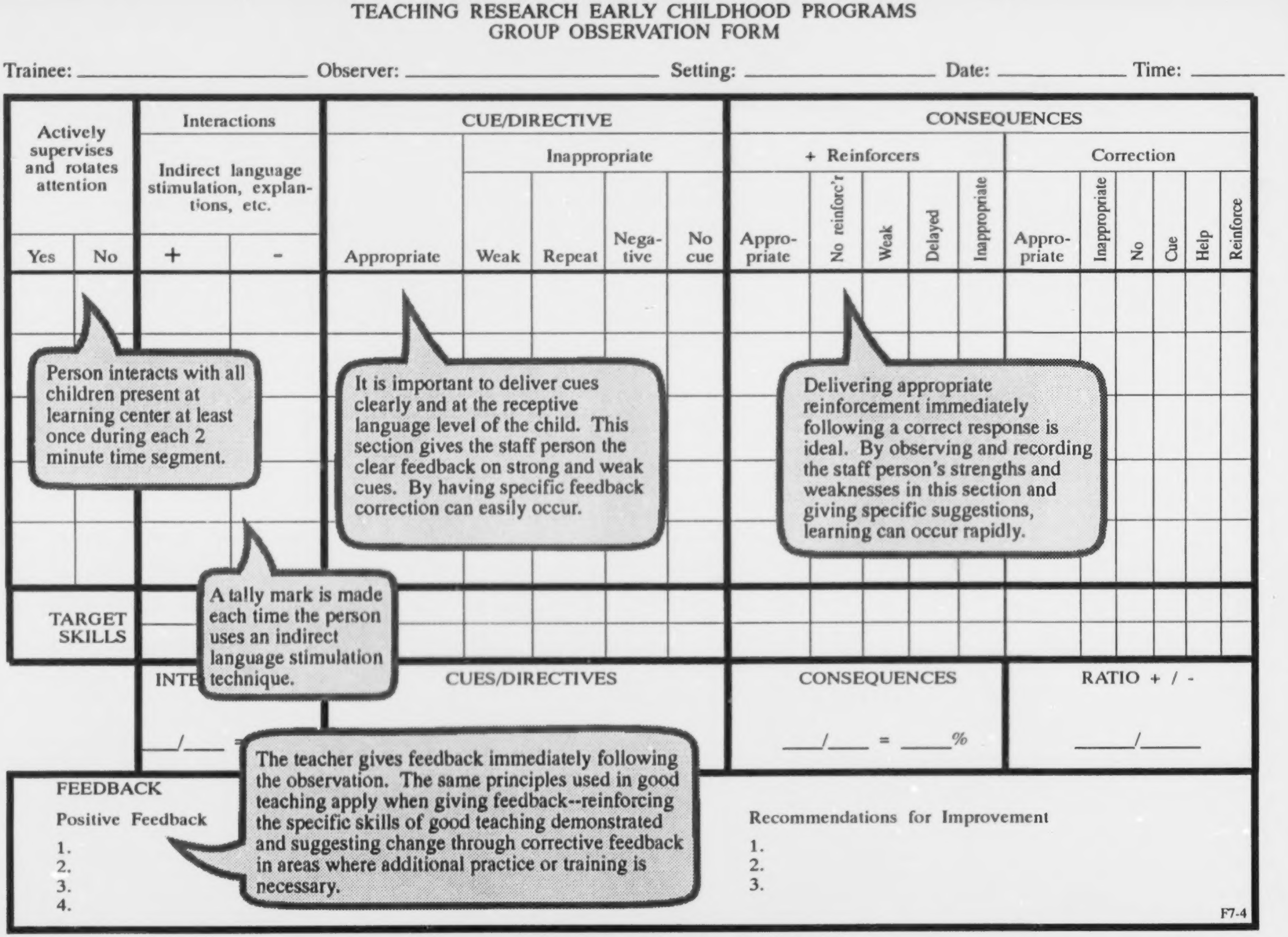
Cues.

- Appropriate: Cue is given clearly and at the receptive language level of the child.
- Weak: Does not have child's attention, is not stated clearly, is not loud enough for child to hear, or is asked in a question format when no choice is intended (i.e., "Are you ready to work?").
- Repeated: Cue is repeated before behavior occurs.
- Negative: Inappropriate wording is used.
- No cue: No cue is given. For example, for child with hearing impairment, no sign is given.

Consequences.

- Appropriate positive: Positive reinforcement is delivered immediately after correct response. Reinforcement is appropriate to child and task and, if tangible reinforcement used, is paired with social praise. This column is also marked every time a positive reinforcement occurs whether a cue is delivered or not.
- No reinforcer: Child is not reinforced after a correct response.
- Weak: Positive reinforcer is not clearly stated, loud enough or with enthusiasm.
- Delayed: Positive reinforcer is delayed 2-seconds or longer after correct response.
- Inappropriate: Positive reinforcement is given immediately following the occurrence of an incorrect or no response.
- Appropriate correction: All four parts of the correction procedure are used immediately after an incorrect response is given.
- No correction: Child responds incorrectly and none of the four parts of the correction procedure is used.
- Inappropriate correction: Correction procedure is utilized, but does not include all four parts. Mark once in inappropriate box and for feedback to trainee, mark under corresponding box those parts that were not included.
  - No: Person did not provide any negative feedback.
  - Cue: Person did not restate the original cue, changed the wording; cue was weak or repeated.
  - Help: Person left out whatever assistance necessary to ensure correct child response.
  - Reinforcer: Mild social reinforcer not delivered at the end of the correction procedure, or was too enthusiastic.

Target skills. This section can be used when the person is working with a child who has skills that are targeted on a clipboard. When using this portion of the observation form, the teacher will be looking to see that cues are delivered appropriately, if consequences are followed based on the response of the child, and that data are collected on the targeted skill.



TEACHING RESEARCH EARLY CHILDHOOD PROGRAMS
GROUP OBSERVATION FORM

Trainee: ____________ Observer: ____________ Setting: ____________ Date: ________ Time: ________

Actively supervises and rotates attention		Interactions		CUE/DIRECTIVE					CONSEQUENCES										
		Indirect language stimulation, explanations, etc.			Inappropriate				+ Reinforcers					Correction					
Yes	No	+	-	Appropriate	Weak	Repeat	Negative	No cue	Appropriate	No reinforc'r	Weak	Delayed	Inappropriate	Appropriate	Inappropriate	No	Cue	Help	Reinforce
TARGET SKILLS																			

Person interacts with all children present at learning center at least once during each 2 minute time segment.

It is important to deliver cues clearly and at the receptive language level of the child. This section gives the staff person the clear feedback on strong and weak cues. By having specific feedback correction can easily occur.

Delivering appropriate reinforcement immediately following a correct response is ideal. By observing and recording the staff person's strengths and weaknesses in this section and giving specific suggestions, learning can occur rapidly.

A tally mark is made each time the person uses an indirect language stimulation technique.

INTE	CUES/DIRECTIVES	CONSEQUENCES	RATIO + / -
___/___ =		___/___ = ___%	_____/_____

The teacher gives feedback immediately following the observation. The same principles used in good teaching apply when giving feedback--reinforcing the specific skills of good teaching demonstrated and suggesting change through corrective feedback in areas where additional practice or training is necessary.

FEEDBACK

Positive Feedback

1.
2.
3.
4.

Recommendations for Improvement

1.
2.
3.

F7-4

Figure 7-4. Observation Form for Staff Training

Scoring.

- Interactions: # of appropriate interactions/total # of interactions = % of appropriate interactions.
- Cues/Directives: # of appropriate positive plus the number of appropriate corrections/total # of consequences = % of appropriate consequences.
- Ratio of Positive to Negative: # of positive consequences/# of appropriate corrections plus inappropriate corrections in which negative feedback was given = positive to negative ratio.
- Guidance/ROT: # of appropriate responses/total number of responses = % of appropriate responses.
- The objective in training staff to facilitate learning in the activity centers is to get them to the level where they achieve a level of 85% appropriate cue and consequences as measured on the Group Observation Form.

Feedback. List any specific positive comments that you can share with the person as well as any recommendations for improvement.

Observation Feedback

After the staff member has had the opportunity to work with children in the classroom, it is necessary that the teacher provide some type of feedback. The use of the Group Observation Form that was described above gives the teacher an instrument that enables precise feedback on the staff member's performance. The teacher should give feedback to the staff person immediately following the observation. In delivering feedback, the teacher will apply the same principles used in changing the behaviors of children. The teacher will reinforce the teaching skills displayed by the staff member, as well as seek to change or improve, through corrective feedback, those areas in which additional practice or training is indicated.

The guidelines below have been used successfully by staff in TRIP classrooms to deliver feedback to persons who have been trained in the model.

1. When conducting the first observation, wait until the end of the session to give feedback. This observation will serve as the baseline.

2. During subsequent observations, intervene if the staff person makes the same error twice within the same category on the observation form. For example, the staff member may repeat the cue twice in two trials.

3. When two or more errors are made within the same category, use the following procedure:

   a. Verbally prompt the staff person (i.e., "Give the initial cue only one time").
   b. Mark the observation form with the appropriate mark.
   c. Should the staff person correct herself on the next trial, reinforce for the appropriate response (i.e., "Good, that time you only gave the cue one time.").
   d. Should the staff person repeat the error, physically or verbally model the appropriate response. When it is the staff person's turn again, reinforce her if she self-corrects and proceed with the program.
   e. If the staff person repeats the error, employ an alternative procedure. Possible strategies might include using physical or verbal prompts as well as modeling, reduce the number of children in the group, work with a group of children who are more compliant, role-play, or videotape the staff member so he or she can see the error as well as the correct response.

4. When delivering feedback after the session, begin with a minimum of two positive statements regarding the performance.

5. In pinpointing weak areas of performance, be specific and give concrete suggestions

for improvement.

6. If the staff person has "bombed out," select one area to give feedback. You may generally mention the other areas, but restrict comments and training to one of two specific ideas. Remember, the goal is to shape the person's skills, not to make the experience aversive.

7. In giving feedback, use terms such as "areas to work on," "skills to practice." Do not use terms such as "wrong, terrible, bad."

8. Give the staff person recommendations and suggestions for improvement in those areas pinpointed as weak. If the staff person has done an exceptional job, the recommendations offered may apply to more advanced skills, whereas a person who is having numerous difficulties would receive more elementary suggestions.

On-going Training and Assistance

Training for staff members is an ongoing process that occurs throughout the year; it is not done only at the beginning of the year. It is imperative that staff be given ongoing observations and feedback to insure that their interaction skills with children are maintained. Without these periodic checks, even the best of staff can fall into inappropriate habits and become imprecise in their teaching techniques. Therefore, formal observations should begin with the staff's initial interaction with a child and be conducted on a periodic basis thereafter.

As the staff members demonstrate increased competency, the level of training can increase in sophistication. More advanced indirect language stimulation techniques, behavior management strategies, and other topics can be covered once the staff members have mastered the basic competencies.

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Chapter Eight

PARENT INVOLVEMENT

Carol Bunse and Tom Udell

Families are vital to the operation of quality early childhood programs, for the family is the pivot around which services revolve. Although family involvement may be more difficult in an integrated setting since more children and adults are involved than in a self-contained program, there are a number of reasons that active family participation should be encouraged. This chapter will describe the TRIP model approach for family involvement that is sensitive to the changing needs of families.

Rationale

P.L. 99-457, Education of the Handicapped Amendments of 1986 and P.L. 101-476, the Individuals with Disabilities Education Act of 1990, direct teams to work together with the family to plan for and provide early intervention services to infants, toddlers, and young children with special needs. The emphasis on family in the law provides legislative credence to family involvement and has emphasized to all agency personnel the importance of including the family in all aspects of the intervention process.

In addition to the legislative mandates, family involvement makes sense for a number of reasons. Bricker (1989) indicates that "early intervention programs which actively focus on the parent or include the parent as an important part of the intervention program produce significantly greater effect on the children than programs that do not have strong parent involvement" (pp. 1-8). Turnbull, Turnbull, and Wheat (1982) believe the reason is much simpler than research and statistics. They indicate that it is the parents' basic right to be involved in their child's educational program, as the responsibility for the child lies with the family.

Historically, family involvement can be traced from an early view of the parents as the source of the problem to the more recent emphasis on parent involvement. Unfortunately, it is only in recent years that early intervention practitioners and others truly began to understand that family involvement was not limited to the parents rubber stamping the recommendations of the professional team members. Families are now being viewed as competent decision makers, able to select their own level of involvement according to their values, resources, strengths, needs and supports (McGonigel & Garland, 1988).

With the family forming a part of the decision-making team, the choices made will be more firmly based on the real needs of the child. Keeping families involved at various levels throughout their child's program has the added advantage of providing them with skills and knowledge to act as change agents. In other words, as a team the educator and the family can extend the child's educational opportunities to all aspects of the child's life: home, school, and community (Bailey & Simeonsson, 1988).

Another important benefit of family involvement is the opportunity to meet with other parents and enter into mutually supportive relationships with them. Finally, when families are involved and understand the programs their children are involved in, they can serve as better advocates and community spokespeople for future or expanded programs. There is much to be gained by facilitating family involvement in advocacy efforts. We need only look to the many improvements in services over the last 30 years brought about by work of the nation's strongest parent advocate group: the National Association for Retarded Citizens.

Considerations In Pursuing Family Involvement In Programs

In order for families and service providers to feel comfortable with the families' level of program involvement, individual characteristics of families as well as involvement options should be considered. In some families, the parent or parents are at work during the day and are not able to attend daytime conferences or visit their child's program. If the child is medically fragile, the parents' main concern may be their child's survival and mounting medical bills. Other families must expend most of their energy in obtaining food and maintaining a place to live. Some have physical or personal problems themselves. In all cases, families today have many priorities in addition to working with their child with handicaps, and programs must be aware of these family priorities if they wish to have family members as an effective part of the child's service team (Bailey & Simeonsson, 1988).

Goals For Family Involvement

When developing a model for family involvement it is important to establish guidelines for program staff to use as they work with families. Although all families have needs, a family who has a child with a disability should not be a problem in need of a solution (Dunst, 1985). Ann Turnbull (1990) describes some approaches and outcomes that can guide early intervention staff who would like families to have increased skills and confidence in their strengths when they leave the program:

Early intervention service providers should make sure that their interactions with families do not promote a dependent, powerless feeling rather than empowering them. For example, although it is important to empathize with families' concerns, it is not helpful to constantly discuss the drain that a special needs child can be on a families' resources. Part of a provider's role is to assist the family to identify the positive impact that their child has on the family, that is, greater sensitivity to individual differences, a new group of friends who also have children with disabilities. This is not to indicate that only positive aspects of the child should be discussed, but that a balance is necessary.

In keeping with the goal to make a positive contribution to the family which has a child with disabilities, providers must work to accentuate the inherent strengths of the child rather than continually focusing on weaknesses the child exhibits. For example, a 4-year-old may not be able to walk independently, but may love to sing and may know many songs. If the entire team is aware of the child's strengths, the child will be perceived more positively than if weaknesses are the main focus during the planning process. It is the role of the service provider to assist families to identify their own resources to build upon for the future.

In the past it was thought that children with special needs would grow up isolated and lonely if they were not placed in segregated programs with other children with special needs. The success of children in integrated programs, however, has disproved this premise. Providers can prepare parents to expect integrated services and the benefits their child can gain from them. This can be accomplished by providing transition activities such as visits to local preschool programs and by including community-based activities in the infant and toddler program. They can also assist parents to network with other parents. When providers give parents networking opportunities to informally discuss the challenges and benefits posed by integrated settings, they can begin developing their own solutions to problems that surface.

In order for families to make wise choices in the early intervention system and later in the public school system, they need to know that their decisions will affect what happens to their child. Assisting families to feel confident that their input is important can begin in the earliest years by ensuring that the family has a part in the assessment process, determines goals, makes decisions about placement, and contributes to the IFSP process.

Finally, a provider can assist a family to plan wisely for their child by presenting a picture of long-range goals for the child that is not only realistic, but optimistic. Presenting the child's possibilities for the future in an optimistic way does not give the family false hope but presents a positive outlook on what is achievable.

Family Involvement Strategies

The TRIP model provides opportunities for family involvement along a continuum depending upon the needs of the family and the age of the child with special needs. To encourage the family members to participate actively in their child's program, staff conduct ongoing assessments of family needs and interests. Using a combination of informal discussion and the Evaluation and Programming System Family Interest Survey (FIS) (see Figure 8-1) developed by the University of Oregon, family members are asked to state their preferences in terms of obtaining information that affects their family. They are asked to complete a section about family interests and community interests, about what services will look like for their child, and how they would like to get information. Some parents may choose primarily home-based services; others may wish to attend a toddler group. They are asked to complete a section about family and community interests including the need for respite, meeting with other families, and obtaining financial assistance. It is also important for a service provider to be aware of whether a family would like to have reading material about their child's disability or whether a videotape would be more useful. Using the FIS format, families may choose between several format choices (see Figure 8-1). This information is updated periodically to account for families' changing interests and needs.

It is important to note two points regarding the use of the family interest or needs scales. First, they should not be considered to be the sole map of family needs throughout the child's stay in the early intervention program. Just as child needs change, areas that are of high priority when a child is an infant may no longer be priorities when he or she becomes a toddler. An example of this would be the premature infant with medical problems. Initially, the family's major concern may be to ensure that the child gains weight and becomes healthy. By the time the child is 1 year old, health problems may be resolving and the family may be more interested in a family support group. The FIS should be updated at least yearly. The second point is that the direct service provider usually is not able to address all of the priorities identified by the FIS and should make this very clear to the family when the survey is presented. However, the provider should be aware of other services in their community who may provide the needed service. They may then refer families to these agencies who may be able to meet their additional needs.

Use of a functional, curriculum-based, assessment process facilitates active family involvement. This would include a survey (formal or informal) of the child's environment asking the family members to identify what they consider priorities for their child and how they would like to see these priorities addressed.

Staff in the TRIP model also use the more formalized Assessment, Evaluation and Programming System (AEPS) assessment. This assessment is completed primarily by observing the child during a variety of activities, interviewing the parent and, if necessary, through direct testing. Where possible, assessment is done by a team including the parent, teacher or home-based provider, and appropriate support specialists (see Figure 8-2 for a sample page from the AEPS II). When all of the information is assembled, the family becomes part of the team along with relevant service providers to

EVALUATION AND PROGRAMMING SYSTEM
FAMILY INTEREST SURVEY

Child Interests

I am interested in:	A Priority Interest	An Interest But Not A Current Priority	Not An Interest At This Time	Format Choice
1. knowing more about my child's current strength and needs.	☐	☐	☐	______
2. learning about services and programs for my child.	☐	☐	☐	______
3. knowing more about my child's condition/disability.	☐	☐	☐	______
4. making plans for future services and programs.	☐	☐	☐	______
5. knowing how my child grows and learns (such as social, motor, communication, self-care).	☐	☐	☐	______
6. learning ways to care for and help my child (such as positioning, handling, diet, health, feeding).	☐	☐	☐	______
7. learning about laws that affect my child, my rights, and how to be an advocate for my child.	☐	☐	☐	______
8. teaching my child.	☐	☐	☐	______
9. managing my child's behavior.	☐	☐	☐	______
10. learning to talk and play with my child.	☐	☐	☐	______
11. talking with teachers and professionals about my child's program.	☐	☐	☐	______

Family Interests

I am interested in:	A Priority Interest	An Interest But Not A Current Priority	Not An Interest At This Time	Format Choice
12. explaining my child's special needs to siblings, grandparents and friends.	☐	☐	☐	______
13. gaining support for my child's brothers and sisters.	☐	☐	☐	______
14. involving family and friends in my child's care or free time.	☐	☐	☐	______
15. counseling for my family.	☐	☐	☐	______
16. learning to solve family problems ourselves.	☐	☐	☐	______
17. gaining more support for myself (friends, partner, neighbors, minister, etc.).	☐	☐	☐	______
18. gaining more support for my partner (friends, neighbors, family members, etc.)	☐	☐	☐	______
19. having time for myself.	☐	☐	☐	______
20. having fun, recreation with my family.	☐	☐	☐	______

Family interest survey form. Source: Bricker, D. (Ed.). (1993). Reprinted by permission. For further information please contact Juliann Cripe, Coordinator, EPS Outreach, University of Oregon, 901 E. 18th Avenue, Eugene, OR 97403.

Figure 8-1. Example of Family Interest Survey

Community Interests

I am interested in:

	A Priority Interest	An Interest But Not A Current Priority	Not An Interest At This Time	Format Choice
21. meeting other families.	☐	☐	☐	______
22. joining parent support groups or groups for children with special needs (United Cerebral Palsy, Muscular Dystrophy Foundation, etc.)	☐	☐	☐	______
23. learning about resources or agencies for help with:				
medical care	☐	☐	☐	______
dental care	☐	☐	☐	______
financial assistance	☐	☐	☐	______
food	☐	☐	☐	______
housing	☐	☐	☐	______
furniture, clothing, supplies	☐	☐	☐	______
transportation	☐	☐	☐	______
legal aid	☐	☐	☐	______
health insurance	☐	☐	☐	______
employment services	☐	☐	☐	______
vocational training	☐	☐	☐	______
crisis intervention	☐	☐	☐	______
toys, adaptive equipment	☐	☐	☐	______
24. finding day care or preschools for my child.	☐	☐	☐	______
25. finding babysitting or respite care.	☐	☐	☐	______
26. finding help to adapt the house for my child's needs.	☐	☐	☐	______
27. talking effectively about my child's and family's needs with professionals and agencies.	☐	☐	☐	______
28. including my child in activities (church, temple, recreation, camps, etc.)	☐	☐	☐	______
29. volunteering with other families or projects.	☐	☐	☐	______

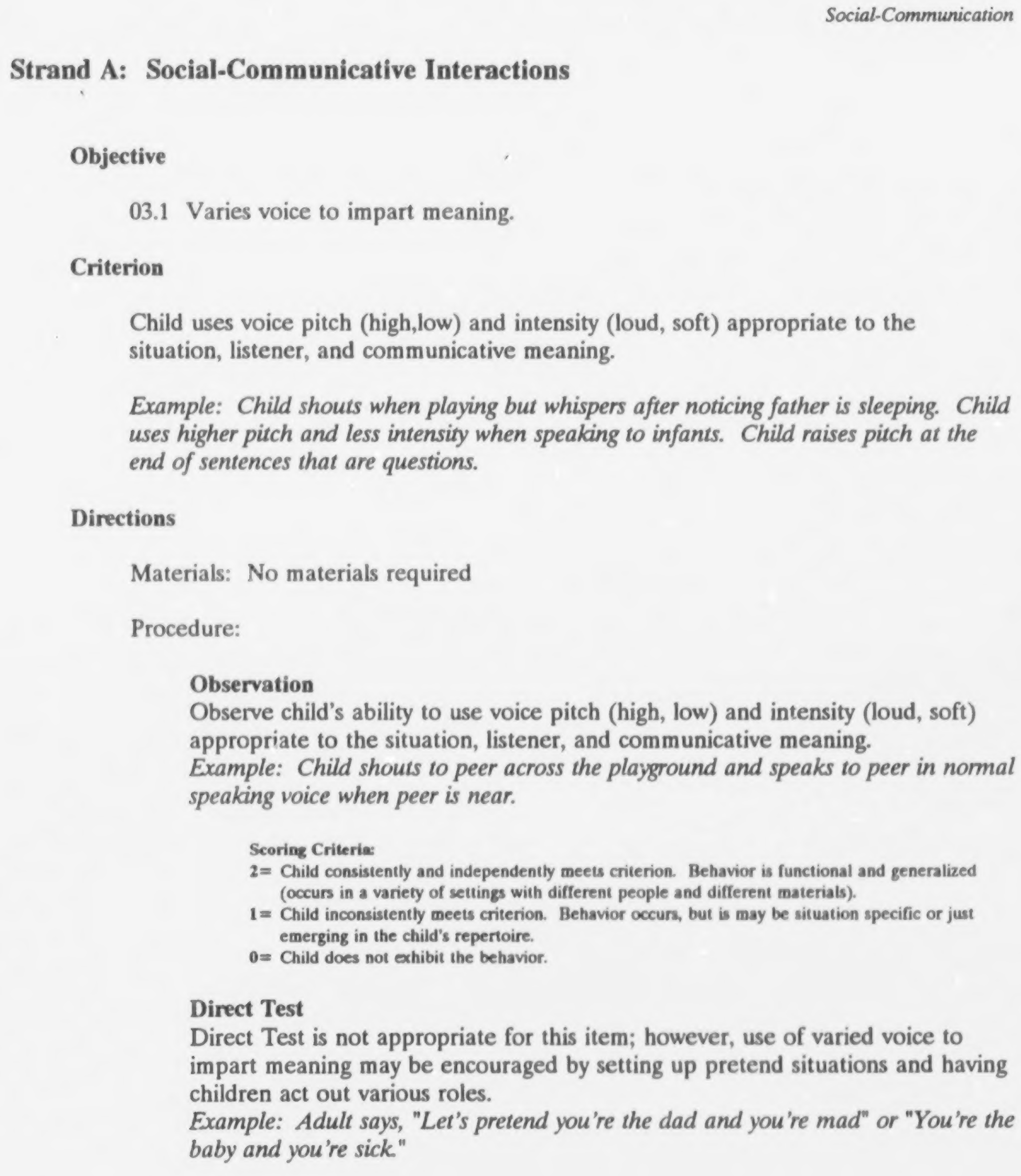
30. other interests or needs:

____

____

____

Figure 8-1 continued



Social-Communication

Strand A: Social-Communicative Interactions

Objective

03.1 Varies voice to impart meaning.

Criterion

Child uses voice pitch (high,low) and intensity (loud, soft) appropriate to the situation, listener, and communicative meaning.

Example: Child shouts when playing but whispers after noticing father is sleeping. Child uses higher pitch and less intensity when speaking to infants. Child raises pitch at the end of sentences that are questions.

Directions

Materials: No materials required

Procedure:

Observation
Observe child's ability to use voice pitch (high, low) and intensity (loud, soft) appropriate to the situation, listener, and communicative meaning.
Example: Child shouts to peer across the playground and speaks to peer in normal speaking voice when peer is near.

Scoring Criteria:
2= Child consistently and independently meets criterion. Behavior is functional and generalized (occurs in a variety of settings with different people and different materials).
1= Child inconsistently meets criterion. Behavior occurs, but is may be situation specific or just emerging in the child's repertoire.
0= Child does not exhibit the behavior.

Direct Test
Direct Test is not appropriate for this item; however, use of varied voice to impart meaning may be encouraged by setting up pretend situations and having children act out various roles.
Example: Adult says, "Let's pretend you're the dad and you're mad" or "You're the baby and you're sick."

EPS II assessment sample. Source: Bricker, Bailey, Slentz, & Kaminski. (1989). Reprinted by permission.

Figure 8-2. EPS II Assessment Sample

determine priority goals for the child and family. The family has the option of using the Individual Family Service Plan (IFSP) planning guide as a means of facilitating this process (Figure 8-3).

The planning guide may also assist families to feel more confident in expressing their needs at the individual family service planning meeting. The goal for all families to have the option of involvement in program planning at the level described above is seen as essential to the long-range success of the child with special needs in school programs. The preschool years are an ideal time to prepare families to be a functioning member of their child's team. Families who have had the opportunity to be a functioning member in the team planning process during the preschool years will have skills that will be useful to them and to their child throughout the child's public school years.

The delivery and level of service a child receives should be based upon the needs determined by the family. After the IFSP team prioritizes goals, it determines how those goals will be implemented. For some children, a preschool setting with consultants will be the format chosen. However, some parents might choose to teach their preschooler at home and the team should be prepared to work with the family to accommodate each child's needs. The family should be the driving force in determining service delivery.

As an example, families with young infants usually choose home visits, a more family-intensive option, as the primary service format. As the child grows, the family may place their child in a preschool program and request that the team consider delivering services at the preschool which would be more child intensive. Figure 8-4 summarizes family- and child-intensive service options demonstrating family-intensive versus child-intensive service option.

Families receiving home-based services have several types of service options. Family preference or need should guide the team recommendation that determines services needed. The service provider may assist the family to access needed services and network with other parents. He or she would also serve as a coordinator if a number of support specialists are working with the child. They might assist the parent to determine activities that occur at home that would help their child to learn new skills. The family would then work on these skills during daily activities with their child. Some families choose to track these skills as they occur and have the service provider update them so the child can continue progressing. Other families prefer to work on the skill themselves but have the service provider track progress. Most important, the service provider would serve as a support and a source of information for the family while assisting them to identify and develop their own support system.

Families involved in center-based services may also choose from a variety of options. If the program is in an integrated setting, they may choose to relate to program staff in the same way as families of typical children: providing occasional treats, assisting with fundraising, sending notes back and forth, and attending special events.

For families who wish to have closer contact with what is happening with their child in the center, there is the option to receive training through the center and function as a volunteer in a classroom. This option gives the family member a chance to see how the child functions in a different environment, give the classroom staff more information about the child, and learn about ways of interacting with the child.

Families who would like to see better follow-through in the home environment on skills taught in school, may choose to work at home on some specific objectives set up by the staff. Some families will wish to track progress by collecting data; others will prefer to provide the classroom staff with anecdotal information.

Teaching Research Early Intervention Program
IFSP Planning Guide

Name:____________________ **Date:**_________________________

STRENGTHS & RESOURCES	CONCERNS & PRIORITIES

RECOMMENDATIONS

Figure 8-3. Planning Guide

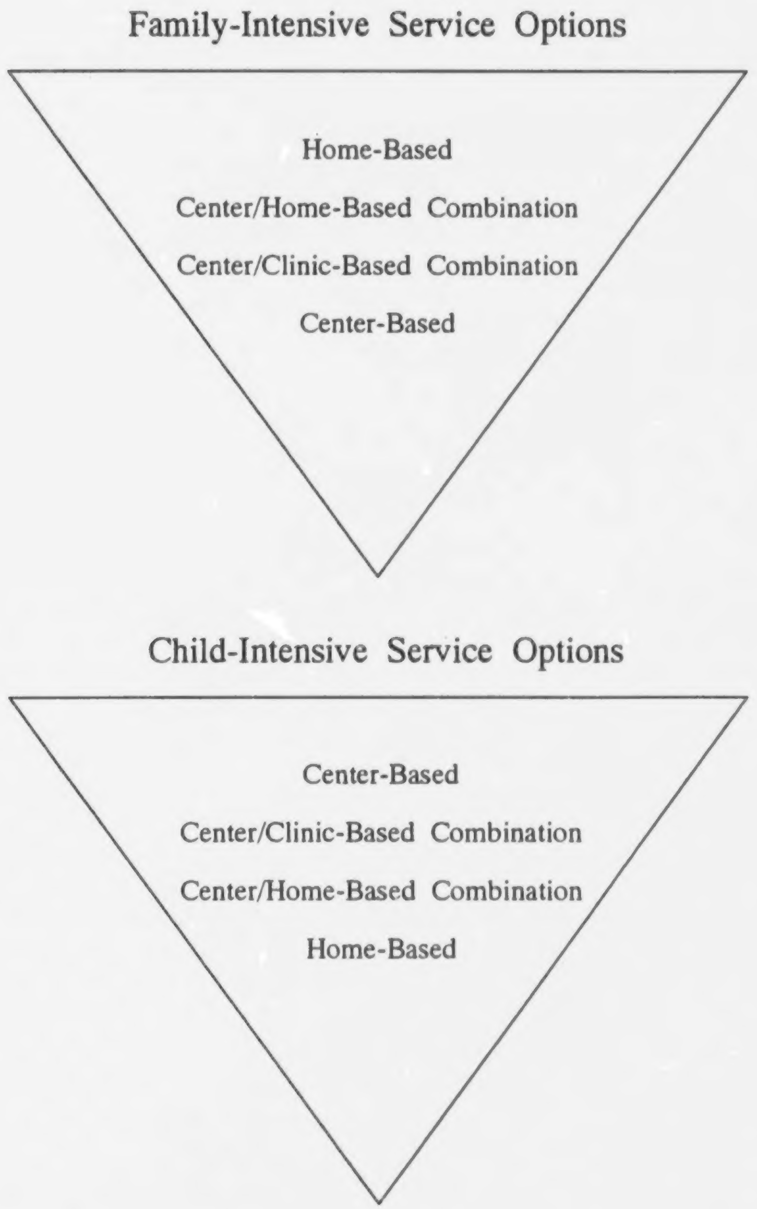

Family-Intensive Service Options
Home-Based
Center/Home-Based Combination
Center/Clinic-Based Combination
Center-Based
Child-Intensive Service Options
Center-Based
Center/Clinic-Based Combination
Center/Home-Based Combination
Home-Based

Figure 8-4. Service Options

Some families, particularly those with preschool children, will identify behavioral issues for which they would like assistance. For these families, a combination of center-based and clinic-based services is usually set up. For clinic services, the family meets at the center on a regular basis with the early intervention coordinator who assists them by providing information on parenting skills and develops a specific behavioral program for their child. The family then tracks weekly progress and the teacher makes suggestions for changes as needed. The following description is a composite of the TRIP IFSP process as it was used with several families in the local early intervention program.

Case Study

Miguel is a year-old boy with low muscle tone and a global developmental delay. He is the youngest of three children. The older siblings are progressing through normal developmental stages. Miguel's parents are both professionals; his mother works part time. The family's interests and hobbies focus around the small farm on which they live. The farm keeps them very active and they are involved in a number of civic groups in the community.

Prior to the IFSP meeting Miguel's mother enrolled him in a private preschool program serving children with and without disabilities model. Upon entry into the preschool program, the parents attended the general orientation and completed the needed paper work including a parent involvement questionnaire. They indicated on the questionnaire interest in volunteering time for a holiday party, sharing an interest or hobby with the children, and that they would be willing to contribute a baked item for a fundraiser. This information was shared with the teaching staff for the future.

Miguel's mother was able to attend the first 2 days of preschool to observe and assist in the classroom. She was able to share with the staff some helpful mealtime procedures as well as some methods of communication. The staff were able to talk with Miguel's mother about any concerns she had about Miguel starting preschool.

During the first 3 weeks of preschool, the special education itinerant teacher completed instructional and standardized assessments. The family completed a Family Interest Survey, and a parent assessment similar to the base assessment used by staff. Miguel's father was also able to observe 2 hours one morning. The special education coordinator made a home visit and helped Miguel's parent fill out an IFSP planning guide and establish a date for the IFSP meeting. At the meeting Miguel was determined eligible for services and the team then began looking at functional goals for him.

On the IFSP planning guide the parents indicated that, in addition to the teacher and early childhood coordinator, they hoped Miguel's associate teacher, the program's speech and language therapist, and the physical therapist that had previously worked with Miguel would be able to attend the meeting.

They shared their observations that Miguel had made many physical gains over the last year. He had progressed from standing with support to independent walking. They also were pleased that he was showing interest and anticipation of some routines. They said he had recently begun to anticipate when it was time to feed their two dogs and seemed to enjoy helping.

Both parents felt one strength of the family was the support of Miguel's grandmother, who was now living near them. They also indicated that they felt strong support from each other. The parents' clear understanding of community resources was also listed as a strength.

The parents were able to state clear goals for Miguel. The highest priority for them was communication. They wanted Miguel to be able to ask for something he wanted and tell them without crying when he did not want something. They also hoped that he would begin to show more interest in toys.

Areas of interest were also generated from the Family Interest Survey. Resources for respite care and drop-in child care, learning about resources for adaptive toys, and more about teaching Miguel, working on communication and preschool options for Miguel's sister, Lisa, were areas in which Miguel's parents were interested in getting more information.

An IFSP meeting was held with Miguel's father, the early childhood coordinator, the head teacher, the associate teacher, and the program's speech and language therapist in attendance. Assessments were reviewed and goals and objectives established. During the process, the team used the planning sheet completed by the parents and addressed many of the family's needs. Resources for respite care were discussed and the family was referred to the county respite care coordinator. The family was also referred to a local child care center that served children with special needs on a drop-in basis.

The parents' interest in finding resources for adaptive toys was addressed both through establishing objectives for Miguel as part of the IFSP and providing catalogs from which the family could order materials.

Because these services were provided in an integrated setting, the option of Miguel's sister attending preschool with him was discussed. It was decided that the parents would investigate transportation issues and report back to the staff.

The parents' interest in learning more about teaching Miguel was discussed. The parents had two requests. First, they were interested in learning more about language development. It was decided that the speech and language therapist would send home some written information and a video tape on prelinguistic language development.

The parents and the physical therapist both voiced concern that it might be difficult to implement therapy routines during daily activities. This was seen to be an ongoing area of concern, and the therapist agreed to do additional classroom observation to assist in making routines functional.

The parents also wanted to know what was being worked on in the classroom and how they could do the same at home. Although they planned on seeing Miguel in the classroom and helping out now and then, they did not feel this would be frequent enough to provide the level of information they desired. It was established that a daily, written communication system between the classroom staff and the parents would be used. The speech and language therapist would also make entries when she worked with Miguel, keeping the parents informed of progress and strategies being used. It was felt that video tapes of Miguel working with the therapist could be an effective and manageable way of showing techniques being used in the classroom. These could be made and sent home every few months. During the months following the IFSP meeting, both parents were able to participate in the classroom. On one occasion, Miguel's mother brought a turkey they were raising to show the class. She was also able to help out during the classroom's Halloween party, and Miguel's father observed several classes. As the year progressed, Miguel parents stayed actively involved, although their schedules allowed infrequent participation in the classroom. The sharing of information in writing and on video met their needs well. They were able to implement some of the techniques used in the classroom and kept up-to-date and involved in changes in Miguel's program.

Summary

The philosophy espoused by programs using the TRIP model states that, since the family is the vital link to providing appropriate services to children with disabilities, families should have choices about the types of services they receive and the goals that are determined for their child. The importance of family involvement in planning for a child with special needs can not be emphasized too strongly. Family members know their child the best. They are the consistent thread that runs throughout the child's school experience. Programs that involve parents benefit immensely from that involvement.

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Chapter Nine

THE ROLE OF RELATED SERVICE PROVIDERS

Carol Bunse

Today, in early intervention programs, those who provide related services must do much more than provide isolated hours of speech or physical therapy. Legislation for P.L. 99-142 and P.L. 99-457 is intentionally broad in the area of related services and, as a result, includes a multitude of supportive services to assist a child to benefit from special education (Hylton, Reed, Hall, & Cicirello, 1987). Related services may include vision and hearing specialists, physical and occupational therapists, augmentative communication specialists, autism specialists, nurses, social workers, and others. The related services a child and family receive will vary based on their individual needs. P.L. 94-142 requires that assessment and program plans be developed together by professionals from multiple disciplines and by the parents (National Early Childhood Technical Assistance System, 1989). The passage of P.L. 99-457 further endorsed this approach by extending the same requirements for team assessment and planning for infants, toddlers and preschool-aged children with special needs, and their families.

Early Intervention Team Models

Prior to the passage of P.L. 94-142 related services such as physical therapy, occupational therapy and speech/communication therapy had been provided for young children with special needs through a clinical or isolated therapy model (Bricker, 1989). This model provides individual services in a treatment room separate from the people and places children typically encounter. This method for providing services is closely aligned with the model that is used within medical or clinical settings. Since many therapists are trained in a medical setting, they may be most comfortable in providing service in this traditional format. However, when related services are provided using a medical model, several issues can be identified that are contrary to current best practice in early intervention programs (Bricker & Schiefelbusch, 1984).

The first issue to be considered is effectiveness. Isolated services provided for 30 minutes once or twice a week have generally been found to be ineffective (Nietupski, Scheutz, & Ockwood, 1980). The development of functional skills for most children with special needs requires more frequent and consistent contact. The medical model has also been criticized for effectiveness in the area of generalization of skills. Teaching a child a skill away from the setting where it will be used does not ensure that he or she will be able to use it in environments where it would typically be performed (Bricker, 1989).

The lack of systematic communication between related service providers, interventionists, family members, and others who are members of the child's service team is another problem identified with the provision of related services using a traditional medical model. Removing children from the environment and the people they most frequently encounter to provide related services can reduce or eliminate opportunities for exchanging information. Time, an already limited commodity, must be scheduled by the specialist to discuss therapy progress and activities with each team member. Furthermore, scheduling problems and coordination of services in multiple locations reduce the opportunities to meet with each team member. This can often result in intervention strategies that are not well coordinated. It may even result in conflict, causing confusion for the child and family.

Finally, the delivery of related services using the isolated therapy model is extremely costly. The child-to-service provider ratio is high, resulting in smaller numbers of children served by any one therapist. The traditional medical model requires that the programs allocate significant amounts of money to employ the necessary qualified specialists or for programs to provide less than adequate service to children. Due to the shortage of related service personnel, funding, and the legal requirement to provide adequate service, neither alternative is acceptable.

These issues illustrate the need for the development of a different method for providing related services. P.L. 99-457 delineates the use of a multidisciplinary team approach for assessment, IFSP development, and case management. It advocates the provision of coordinated services.

Team Approaches

Many authors support the superiority of the team approach (Hutchinson, 1974; Lyon & Lyon, 1980; McCormick & Goldman, 1979; Orelove & Sobsey, 1987; Sears, 1981; Woodruff, 1980). Perceived benefits are reported to include more active parent participation in assessment, intervention, and team collaboration (McCormick & Goldman, 1979; Woodruff, 1980) increased professional knowledge and skills through collaboration among team members (McCormick & Goldman, 1979; Orelove and Sobsey, 1987) facilitation of therapy and teaching skills through the child's natural environment (Sternat, Messina, Nietupski, Lyon & Brown, 1977), increased mutual respect and professional growth among team members (Baine & Sobsey, 1983; Ottenbacher, 1982), shared responsibility for problem solving and decision making (Sternat et al., 1977; York, Rainforth, & Wiemann, 1988) and more equal distribution of responsibilities among team members (McCormick & Goldman, 1979). Use of a team approach increases the likelihood that essential skills will be practiced and generalized across settings, and that skills identified are truly ones that are useful to the child.

To be effective in serving the needs of young children with special needs and their families, teams must be more than a collection of professionals pursuing their own interests (Jordan et al., 1988). A variety of team approaches have emerged, including the multidisciplinary, interdisciplinary, transdisciplinary models, and collaborative models (Albano, Cox, York, & York, 1981; Hart, 1977; Orelove & Sobsey, 1987).

Multidisciplinary Model

The multidisciplinary team model was the first attempt to bring related service professionals together to work as a team. Jordan et al., (1988) suggest that although multidisciplinary team members appear to work together, they actually function quite separately. They may have some common goals but overall they view a child in terms of what their area of expertise. Teams using this approach typically conduct separate assessments, and develop and implement separate discipline-specific goals and objectives with little communication with other team members. The multidisciplinary team approach has several weaknesses due to the independent roles and minimal interaction among team members. Another drawback of this model is the low level of family involvement.

Interdisciplinary Model

The interdisciplinary model was developed to answer many of the problems identified in the multidisciplinary approach. This model built on the strengths of the earlier model, with one important distinction; it provides a formal structure for interaction and communication among team members. Furthermore, this model includes families as members of the team. Interdisciplinary team members assess children independently, then come together to discuss their results and develop intervention plans cooperatively. Generally, each team member is responsible for implementing the part of the plan that relates to his or her discipline, and other sections are incorporated where possible. Although this model solves several of the problems identified in the multidisciplinary model, problems still exist. One of the main problems has to do with professional turf. Sometimes professionals do not fully understand the professional training expertise of the other team members. This can lead to power struggles and role confusion.

Transdisciplinary Model

The transdisciplinary model attempts to solve the problems of role confusion and team interaction that occur in the other two models. Although the transdisciplinary model is similar to the interdisciplinary model, it differs in several important areas. First, the transdisciplinary model is based on the belief that the child's development must be integrated and interactive and that the child must be served within the context of the family. In addition, the family is viewed as full, active, and participating members of the team. Another distinction of this model is that team members accept and accentuate each other's knowledge and strengths.

Team members often conduct assessment together with the family. The entire team develops an integrated service plan based upon the family priorities, needs, and resources. The plan is usually implemented by one or two team members who are identified as primary care providers, in conjunction with the child's family (Hutchinson, 1974; McCormick & Goldman, 1979; Woodruff, 1980). Members of the team provide cross-training to other members of the team in their own disciplines to help facilitate this process.

Although this system is effective, it requires extensive amounts of training and small caseloads. As a result, true transdisciplinary teams are seldom seen outside of clinic and university settings. A variation of this model includes an indirect, integrated therapy approach, if appropriate for the child. This approach is a strategy for delivering related services by incorporating therapy goals within activities that naturally occur in the child's home and/or school environments. Indirect integrated therapy implies that therapists will serve as consultants while other team members assume the role of direct service providers.

Collaborative Model

The collaborative team approach combines components of the interdisciplinary and transdisciplinary approaches. The focus of the team is to enhance the child and family's ability to function in their environment. A collaborative approach helps to ensure that the entire range of needs for a child and family are identified and integrated into a functional plan that is developed in a timely fashion (Prentice & Spencer, 1985).

Implementation of a collaborative team model for related services requires cooperation from all participants. Administrative personnel from all agencies involved must have a clear understanding of the types of time commitments necessary on the part of support staff to achieve a successful team effort. Though support personnel may provide fewer hours of hands-on service per child with this model, it is imperative that time be scheduled for team members to meet for group assessment of children, goal planning, and ongoing evaluation of progress.

Support personnel must be willing to share information and release a part of their traditional direct service role by training classroom and other staff to implement routines and recommendations. Classroom staff and parents need to work with support staff to devise ways to include recommendations into the child's daily routine.

Support Service Teams

Based on research and on the very nature of an activity-based preschool model, in an integrated setting a version of the collaborative team approach is usually the most suitable and effective method for delivery of support services. This is the type of system supported by the TRIP model. The role of a support specialist is necessarily more complex than that of traditional ancillary staff. To enable a child with special needs to function effectively in the environment and benefit from the educational program, the roles of the specialist, particularly at the preschool level, must include those of team member, consultant, trainer, direct service provider, and evaluator.

Support specialists can be more effective in their roles, and classroom staff can better utilize support services, if their responsibilities are clearly defined. Role definition encompasses determining which children need ancillary services, what type of services will be provided and how those services interface with other services the child is receiving. Protocols must be adopted for these determinations. These serve as guidelines for all members of a child's early intervention team.

Role of the Support Specialist In The Collaborative Team

Support specialists in a collaborative team may use a set of flexible guidelines developed by Hylton, Reed, Hall, & Cicirello in 1987 when determining service delivery options for a child:

- Initial assessment and determination of need for services
- Provision of direct individual services to a child
- Consultation for specific students
- Inservice to other professionals
- Monitoring of an individual child's progress

Initial Assessment and Determination of Need for Services

During the initial assessment, support specialists who have been identified as appropriate members of that child's team, coordinate their assessments with those of classroom staff and other support specialists. Children are assessed during routine activities in the preschool day. One member of the team who is familiar with both the child and the assessment tools serves as the facilitator during group activities to ensure that the child has an opportunity to perform the skills the observers are looking for. Based on this assessment, the service providers develop a written report summarizing the child's strengths and needs, including recommendations regarding the amount and type of service to be provided (which may include the recommendation for no additional service). If additional service is recommended, the specialist will include goals and objectives for the child along with a listing of adaptive equipment needs.

Criteria for determination of a child's need for service and the level of service that is most appropriate have been addressed by several authors. Giangreco (1988) developed a listing of essential and discretionary criteria for making related service decisions. The Waukensha Delivery Model (Wisconsin Department of Public Instruction, 1987) describes a level approach to physical/-occupational therapy service delivery based on the rate of change in the student's physical functional status (Table 9-1). Specialists using a collaborative approach might use these flexible guidelines including four levels of service delivery with general criteria: **provision of direct individual therapy, consultation, inservice activities, and monitoring progress.**

Provision of Direct Individual Therapy

Using the direct service format, a specialist works directly with a child within an activity group in the integrated preschool setting. The only occasion in which services would be delivered in an isolated setting would be in the instance of a medical procedure or activity that required removal of some of the child's clothing, or during certain assessment

Table 9-1. SERVICE DELIVERY MODEL

All students receiving occupational/physical therapy services are assessed and assigned one of four levels of service. The levels of service are based on the rate of change in the student's physical/functional status and may change during the school year. Each level of service defines the purpose of intervention, intensity of service, and the personnel responsible for the delivery of services. Therapists are involved in evaluation, therapy service planning, parent/staff training, and monitoring of student's programs.

Level	Physical/Functional Status of Student	Purpose of Intervention	Intensity of Service	Therapist/Staff Involvement
I	Student is undergoing rapid and/or crucial change in physical/functional status.	Therapy goals are designed to develop functional level or prevent significant regression.	Time commitment may range from 2½-3½ hours per week; of that, 2/3 is targeted on time with student, 1/3 is targeted time on behalf of student. Therapy revisions are frequent.	Physical needs are primarily addressed by the therapist by providing specific therapy techniques, with other personnel involved as appropriate in order to provide a "therapeutic day."
II	Student is undergoing moderate change in physical/functional status.	Therapy goals are designed to develop functional level.	Time commitment may range from 1½-2½ hours per week; of that, 2/3 is targeted as time with student, 1/3 is targeted time on behalf of student. Therapy revisions are periodically necessary.	Physical needs are primarily addressed by the therapist by providing specific therapy techniques, with other personnel involved as appropriate in order to provide a "therapeutic day."
III	Student's physical/functional status is undergoing some change or is stable.	Therapy goals are designed to develop and/or maintain functional level.	Time commitment may range from ½-1½ hours per week; of that, 2/3 is targeted as time with student, 1/3 is targeted time on behalf of student. Therapy revisions are infrequent.	Therapist is now in a more supportive role with other personnel involved as appropriate in order to provide a "therapeutic day."
IV	Student's physical/functional status is stable.	Therapy goals are designed to monitor functional and physical status.	Time commitment is up to 20 hours per school year. Contact frequency may vary (bimonthly, monthly, quarterly). Student may be placed on Level IV to monitor status prior to dismissal.	Therapist will monitor on a needs basis, providing input on student's needs as appropriate. Other personnel may need to continue to follow through on simple recommendations in order to help maintain the student's physical/functional status.

From: Reed, P., Hylton, J., Cicerello, N., & Hall, S. (1988). A model plan for the supervision and evaluation of therapy services in educational settings (p. 45). Madison, WI: Project TIES: Therapy in Educational Settings.

procedures. In the TRIP model, direct therapy is provided in conjunction with consultation with the educational staff, parents, and other members of a child's team. Children who receive direct therapy are generally those who are making rapid or moderate changes, or have multiple involvements that require skills from a specialist that cannot be taught to other staff easily. They may also include children who have recently been referred to the program. Examples of direct therapy might include adapting equipment or repositioning it in the classroom or home setting so the child might participate more fully in age-appropriate activities. When hands-on activities are occurring as in the case of speech, physical, or occupational therapists, ongoing explanations and demonstrations are included for educational staff so that they may implement the recommended procedures.

Consultation for Specific Students

Consultation skills are needed for all levels of service provided by support staff. Consultation would include evaluation of the child, observation of the child during routine activities, written recommendations for activities, training to carry out recommendations, periodic meetings with the team to provide information that will enable to carry them out recommendations, problem solving, and periodic reevaluation to determine whether the service level is appropriate (Hylton et al., 1987).

When providing training support staff use a variety of techniques including demonstrating skill with the individual being trained, having the trainee role-play the skill and receive feedback, and demonstrating with the target child. All training is accompanied by specific feedback on which skills are mastered and which need additional practice. Videotaping and written instruction are a valuable adjunct to the initial hands-on training.

The usual candidate for consultation services would be a child who is making slow progress along the developmental continuum--one who will only improve with intense practice.

Inservice to Other Professionals

Periodically, as new children and staff enter programs, information updates which may or may not be student specific are needed. This type of inservice may be scheduled by the classroom coordinator as part of an annual orientation process or an ongoing staff development program. These inservice activities improve the functioning of teams through the opportunity provided for staff to communicate with each other and ask questions. Inservice sessions are also scheduled in response to specific requests. For example, a new staff member may experience difficulty in lifting a child with cerebral palsy in and out of his wheelchair. The inservice might cover lifting and moving techniques for the entire staff, as well as some specifics about the child in question. When providing this type of inservice, specialists need to be cautioned about using discipline-specific jargon.

Monitoring of Individual Children's Progress

Monitoring is accomplished by observing or working with a student periodically to ensure that the level of service is appropriate and to update any recommendations made previously. Ordinarily, children who receive monitoring from support services are those who have received direct service in the past or are demonstrating satisfactory progress in the preschool program.

Continuum of Services

It is important to remember that most children will receive service encompassing several of the service delivery modes and that they may move back and forth between modes. The service levels are designated as a guideline for teams when determining needs of students and methods for meeting those needs in the most effective way.

It should also be noted that the collaborative team model may need modifications in order to function well in a variety of settings. The modifications required depend upon how a integrated preschool program is staffed, that is, whether all support personnel are employees of the early intervention program or whether other agencies are subcontracted, how well the program is funded and individual personalities who are a part of the team.

Case History

The following case history illustrates the process a team might use when a new student enters an integrated preschool program:

Dennis is a 4-year-old boy with mild cerebral palsy, a communication impairment, and a developmental delay. He has been enrolled in an integrated preschool/child care program in his neighborhood by his parents and a referral has been made to the early childhood special education program. After determining eligibility for early intervention services, the staff allows Dennis 1 week to adjust to the new environment. During that time the special education coordinator contacts the speech therapist, the physical therapist, and the occupational therapist to schedule assessment times. Although scheduling does not allow all four members of the team to assess at the same time, it is determined that the speech and physical therapists will work together to complete part of the assessment, and the classroom teacher and occupational therapist will collaborate on the remainder of the assessment. It is the classroom coordinator's job to see that the other team members are clear on what areas they are responsible for assessing and that they have access to any previous reports regarding Dennis' development.

During Dennis' second week in the classroom, the speech and occupational therapist schedule a time during both a group activity and during an outdoor motor time to observe Dennis in the classroom during play activities. They will only pull Dennis out of group activities to complete specific items on the assessment that might not occur in the group. The teacher or one of the classroom associates will be familiar with the assessment being used and will assist in facilitating those activities the therapists need to see. At times, either the speech or physical therapist may assist the teacher or associate in eliciting some of the behaviors needed to determine Dennis' functioning level.

At another time during the week, the teacher and the occupational therapist complete their portion of the assessment. In addition to the functional assessments that occur during school activities, the teacher or the special education coordinator completes a parent assessment with the family to determine the goals that are important for the child in the home setting.

The special education coordinator then sets up a meeting with the specialists involved and the parents. The occupational therapist is unable to attend the meeting but discusses her recommendations with the team member with whom they completed the assessment process. Based on assessments the team determines that Dennis is eligible for early intervention services. It is determined that a strength for Dennis is his ability to participate in most classroom activities, but moves very slowly and clumsily and is frustrated that he can't keep up with his friends. The physical therapist recommends monthly consultation to assist classroom staff to provide appropriate assistance to Dennis during gross motor activities as well as some range of motion exercises that she will teach both staff members and the parent so that Dennis will move more smoothly. The occupational therapist feels that a twice-monthly visit to consult with the classroom staff and provide adaptive equipment (such as special scissors for cutting) will help him increase his skills and speed closer to age level.

The speech therapist notes that a strong area for Dennis is his willingness to communicate with adults and other children. She feels that if he were more understandable he would be less frustrated when he tries to talk. She would like to work with him directly for several weeks during selected times and then train staff to implement her recommended procedures during all activities. In addition, she recommends helping Dennis develop more extensive conversation skills and would like to train staff to work on these during group activities.

The teacher and parent would both like to see Dennis develop more play and interaction skills. The special education coordinator assembles these recommendations along with a summary of Dennis' functioning in areas tested and develops a rough listing of goals for all members of the team. This listing serves as the base for Dennis' Individual Family Service Plan.

Ideally, all members of the team would attend the IFSP meeting. In reality, this does not always occur, due to the heavy caseloads carried by ancillary staff.

In Dennis' case, the team members available were able to craft the ideas and recommendations of the group into a coordinated plan for Dennis.

Summary

To provide the most effective service, current research indicates the need for support personnel to work in a collaborative fashion in the child's natural environment. In order for a team to function effectively it is important for members to have guidelines for assessment, recommendations, and service delivery. When these guidelines are in place, the probability of a child functioning at the optimum level at home, school, and in the community are increased.

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APPENDIX 1

Guidelines for Programs Serving Preschool Children with Handicaps in Oregon in Head Start/Preschool/Day Care/Kindergarten Settings

Guidelines for Programs Serving Preschool Children with Handicaps in Oregon
in
Head Start/Preschool/Day-Care/Kindergarten Settings

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Acknowledgement

The Guidelines presented in this document represent an ongoing effort of the Oregon Department of Education, the Oregon TMR/Autism Working Group, an Oregon Statewide Systems Change Project, and the Early Intervention Evaluation Focus Planning Group.

The items in the Guidelines were derived from several sources. The Oregon TMR/Autism Working Group prepared a draft of guidelines based upon a version of Program Quality Indicators: A Checklist of Most Promising Practices in Educational Programs for Students with Disabilities developed by Luanna Meyer and others at Syracuse University, Syracuse, New York. Additional guideline items were acquired from the Program Review Oregon Planning Guide for the Education of Deaf-Blind Students completed by the Oregon Working Group for Deaf-Blind Individuals. Some of the guideline items were adapted from Best Educational Practices assessment instrument, developed and validated by Wayne Fox and others at the University of Vermont, Burlington, Vermont.

Additional guideline items were adapted from To Be the Best We Can Be: A Self-Study Guide for Early Childhood Special Education Programs and Staff, developed by the Washington State Department of Education.

The individuals who prepared these Guidelines are grateful to all of the above groups and organizations for the use of their documents.

It is expected that the content of these Guidelines will change over time to reflect expanding knowledge in this field.

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Introduction

State agencies, with the Department of Education and the Mental Health Division assuming the leadership role, are encouraging local early intervention providers to offer the highest quality programs possible. To move in this direction requires information about the present status of programs with suggestions for areas of improvement. This set of Guidelines is intended to provide a set of information for assisting providers in this task.

The Guidelines were designed to be used in programs serving children ages three to six years. The most common setting for children in Oregon this age are:

Head Start Classrooms
Preschool Programs
Day-Care Settings
Public School Kindergartens

It is felt that these Guidelines would be most appropriate for children in these settings.

The Guidelines are designed to help document the opinions of providers and parents regarding the quality of programs. The Guidelines are intended to be used as an interview document and can be used to identify both strengths and areas needing improvement.

The following sections provide suggestions on how to use the Guidelines to acquire information about a program. Suggestions for use of the information are also provided. A process to use to acquire the information is presented. The process is composed of the following steps:

1. Identify local assessment team;
2. Review necessary documentation;
3. Schedule the assessment;
4. Conduct assessment interview;
5. Develop goals;
6. Develop and implement an action plan;
8. Continue the evaluation cycle.

Identify Local Assessment Team

The first step in conducting the assessment is to identify a Local Assessment Team. It is suggested that a Team be established by the county early intervention local advisory group (LAG). Members of the Team could include LAG providers, ancillary service personnel, parents and other members who would be interested in serving on the Team. A Team should be composed from four to five members. Team members must be thoroughly familiar with the Guidelines prior to using them in the assessment.

Review Necessary Documentation

Prior to conducting the assessment, the Team reviews any written information about the program. This includes a description of the services available, a teacher or parent guide and statements of program philosophy. If possible the following documents reviewed:

1. Current assessment information
2. Individual Program Plans
3. Instructional program plans and ongoing assessment data.

4. Current classroom schedule and the children's daily schedule of activities

A review of this material will help the Team become familiar with the program they are to assess.

Schedule the Assessment

The assessment interview takes between one to two hours to complete. It is helpful if the program teacher, aide and director are available for this period of time to answer questions. One or two parents from the program may also be interviewed using the Guidelines.

If possible, and prior to the interview, the Team should have an opportunity to observe the program. An observation of no more than an hour will help the Team become familiar with the program operation. The observation is not required but is recommended.

Conduct Assessment Interview

During the assessment interview the Guidelines for Programs Serving Preschool Children with Handicaps in Oregon Head Start/Preschool/Day-Care/Kindergarten Settings is used by the Assessment Team. Each item in the Guidelines is assessed and the level of implementation of the item is indicated on the Guidelines. An explanation of each level is provided in the Guidelines.

The Guidelines are completed by interviewing the staff and parents of the project. Based on the responses from these individuals, the Assessment Team completes the Guidelines.

When the Guidelines have been completed, the program staff is dismissed. The Assessment Team then reviews the completed Guidelines to insure that all items have been scored correctly. Once this review is complete, the Guidelines are reproduced and a copy given to the program. A member of the Assessment Team explains the results and answers any questions the staff may have. This occurs within two weeks of the completion of the interview.

Develop Goals

With the help of the Assessment Team, the staff selects areas for improvement. This could be accomplished by ranking the areas on the Guidelines and then identifying specific items to address. The goal development process includes the provider staff, members of the Assessment Team and any other person whose cooperation will be necessary to achieve the goals.

When setting goals, the likelihood for achieving improvement should be considered. If the program staff, administrators and parents support the goals, the possibility for improvement is strengthened.

Develop and Implement an Action Plan

The development of an action plan and identification of areas for technical assistance is the next step in the assessment process. Once the goals for improvement have been identified, objectives and measures for improvement are set and implemented. Members of the Assessment Team, the program staff, and others whose cooperation will be necessary to achieve the goals, are involved in setting the objectives, designing the measures and completing the action plan. At this time, potential need for technical assistance is identified. The type of assistance and potential technical assistance providers is identified.

A suggested action plan is presented below:

1. Goals for improvement of program quality;
2. Objectives leading to the achievement of each goal;
3. Measures to determine acquisition of objectives;
4. Description of needed technical assistance to meet each objective;
5. Person(s) responsible for implementing each objective;
6. Timeline indicating dates when implementation of each objective will occur and be completed.

The action plan should be implemented as indicated by the timeline. Progress toward completing the plan is monitored by the individuals responsible for implementation, by the program administration and interested parents. As progress occurs, the plan may be revised.

Continue the Evaluation Cycle

Assessing program quality and planning program improvement is an ongoing process. One way of continuing the process is to administer the Guidelines on a regular basis. It is recommended that they be used twice yearly. Results from one time period to another can be compared to determine progress. As the action plan is completed, the Guidelines can be readministered to determine next areas of attention.

Research and technology regarding early intervention is continually expanding and as a result the items on the Guidelines will change over time. As the Guidelines are revised to reflect these changes, programs will need to be notified to be appraised of these changes. Use of the Guidelines in the evaluation process will give providers a means to remain current of revisions in early intervention. Thus, the Guidelines provide a means with which to regularly improve the services offered to children in early intervention.

GUIDELINES FOR PROGRAM SERVING PRESCHOOL CHILDREN WITH HANDICAPS IN OREGON HEADSTART/PRESCHOOL/DAY-CARE/KINDERGARTEN SETTINGS

The Oregon Department of Education and the Mental Health Division (hereafter referred to as the State Agencies) maintain that educational programs for preschool-age children with handicaps should address the quality of education in each of the following areas:

Page
- Age appropriate Placement in local Headstart/Preschool/Day Care/ Public School Kindergarten (HS/PS/DC/K) settings 5
- Integrated Delivery of Special Education and Related Services 7
- Social Integration 9
- Transition Planning 11
- Community-Referenced Training 12
- Functional, Longitudinal Curricular Expectations 13
- Classroom Management 15
- Systematic Data-Based Instruction 17
- Educational Environment 19
- Health and Safety 21
- Home-School Partnership 24
- Personnel Development 26
- Systematic Evaluation of Educational and Related Services 28
- Educational/Community Facilities 30

On the following pages, each of the above areas is identified and a description of the area is provided. A Quality Guidelines Checklist follows each description. Each Checklist begins with the same three questions followed by a set of statements indicating quality guidelines for the area. Please respond to each question and statement in the 11 areas.

AGE-APPROPRIATE PLACEMENT

Description:

State Agencies are responsible by law for ensuring that, to the greatest degree possible, preschool children with handicaps are educated with their nonhandicapped peers. The State Agencies are also responsible for ensuring that any removal of preschool children with handicaps from community HS/PS/DC/K environments occur only when the nature or the severity of the handicap is such that education in these environments, even with the use of supplementary aids and services, cannot be achieved satisfactorily.

Furthermore, the State Agencies maintain that placement of preschool children with handicaps into age-appropriate programs within their local community is in the best interest of all children, their teachers and families. The State Agencies are supported in this contention by the State Early Intervention Coordinating Council.

Quality Guidelines Checklist:	**Yes**	**No**
1. Is age-appropriate placement in local settings a goal of your program?	______	______
2. Do you have a written policy for this goal?	______	______
3. Do you provide staff training in this area?	______	______

For the next items, please use the following marking system

No progress = _____
Initiated = _____
Partially Implemented = _____
Implemented = _____

No progress: Nothing has been started in this area.
Initiated: Work has started, but only at the beginning level.
Partially Implemented: Efforts have been started, but have not been completed.
Implemented: This feature has been implemented completely.

Quality Guidelines Checklist:	**Level**	
1. Each child's primary placement is an age-appropriate, integrated program in the community	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
2. There is a written E.I. provider policy describing procedures for removal of children from community programs	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
3. Headstart/Preschool/Day Care/Kindergarten teachers are involved in the development of Individual Placement Plans (IPP)	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______

4. For each child there is written justification for removal from HS/PS/DC/K program

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

5. For a child who is not in a community program, his IPP identifies goals that will lead to his placement in HS/PS/DC/K programs

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

6. Each child's placement is reviewed annually

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

7. There is a written transition plan for increased participation in HS/PS/DC/K programs

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

8. If a child is in a special class for children with handicaps, no more than 12 children are assigned to one teacher

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

INTEGRATED DELIVERY OF SPECIAL EDUCATION AND RELATED SERVICES

Description:

State Agencies maintain that special education and related services cannot be confined to services offered by a specialist for a limited period of time each day or week. Special Education and related services should be provided throughout the entire day. Children should receive special education and related services from teachers, teaching assistants, therapists, nonhandicapped peers, parents and other family members. Special educators and therapists should train and consult with these others, as well as provide direct services. When direct services are provided, these services should occur in the environments where the skills will be used and therapy goals should be integrated into the child's IPP objectives and daily school, home, and community activities.

Quality Guidelines Checklist:	**Yes**	**No**
1. Is integrated delivery of special education and related service a goal of your program?	______	______
2. Do you have a written policy for this goal?	______	______
3. Do you provide staff training in this area?	______	______

For the next items, please use the following marking system

No progress = ______
Initiated = ______
Partially Implemented = ______
Implemented = ______

No progress: Nothing has been started in this area.
Initiated: Work has started, but only at the beginning level.
Partially Implemented: Efforts have been started, but have not been completed.
Implemented: This feature has been implemented completely.

Quality Guidelines Checklist:	**Level**	
1. Related service personnel participate in IPP development when children are in need of such services	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
2. Special education and related services are provided in consultative and direct formats, as needed and specified by IPPs	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
3. Special education and related service personnel train other providers, and conduct follow-up and regularly monitor the programs	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______

4. Special education and related services are provided during classtime, integrating them into child initiated activities, routines and classroom activities	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
5. Parents and other family members have the opportunity for special education and related service consultation, training, and follow-up	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
6. IPP objectives indicate the integration of special education and related service goals into HS/PS/DC/K settings, school, home, and community activities	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
7. Therapeutic IPP objectives and specific education programs emphasize active participation by children in age-appropriate activities	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
8. Alternative, augmentative communication modes are developed for children who need them and their use is integrated into school, home, and community activities	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______

SOCIAL INTEGRATION

Description:

State Agencies maintain that preschool children with handicaps should have access to the same environments as their nonhandicapped peers of the same chronological age. Two goals of social integration are to increase interaction between persons with and without handicaps and to increase the number of integrated community environments in which children with handicaps can participate. Approaches to increasing social interaction should focus on providing skills to all children.

Quality Guidelines Checklist:	**Yes**	**No**
1. Is social integration a goal of your program?	______	______
2. Do you have a written policy for this goal?	______	______
3. Do you provide staff training in this area?	______	______

For the next items, please use the following marking system

No progress = ______
Initiated = ______
Partially Implemented = ______
Implemented = ______

No progress: Nothing has been started in this area.
Initiated: Work has started, but only at the beginning level.
Partially Implemented: Efforts have been started, but have not been completed.
Implemented: This feature has been implemented completely.

Quality Guidelines Checklist:	**Level**	
1. A number of current and potential, age-appropriate, integrated local HS/PS/DC/K environments have been identified	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
2. All children have regularly scheduled, structured opportunities to interact with age-appropriate nonhandicapped peers and other community members within HS/PS/DC/K settings	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
3. Specific procedures for identifying activities and skills required to function in HS/PS/DC/K are used to identify barriers and facilitators to the child's participation in these environments	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
4. IPPs include objectives for increasing social skills in HS/PS/DC/K settings including, preteaching or other play-related behaviors	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______

5. All children are in environments with age-appropriate nonhandicapped peers at least 50% of the time during the day

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

6. Children's transportation is based on their individual needs and provides opportunities for social integration with nonhandicapped peers

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

TRANSITION PLANNING

Description:

State Agencies maintain that preschool children with handicaps require longitudinal planning, involving appropriate persons from current and future environments. This is needed to anticipate changes, and to ensure successful transition from one environment to the next. Individualized Transition Plans are an integral part of each child's IPP. These plans should address transition from one environment to the another, and from restrictive settings into less restrictive settings.

Quality Guidelines Checklist:	**Yes**	**No**
1. Is transition planning a goal of your program?	______	______
2. Do you have a written policy for this goal?	______	______
3. Do you provide staff training in this area?	______	______

For the next items, please use the following marking system

No progress = ______
Initiated = ______
Partially Implemented = ______
Implemented = ______

No progress: Nothing has been started in this area.
Initiated: Work has started, but only at the beginning level.
Partially Implemented: Efforts have been started, but have not been completed.
Implemented: This feature has been implemented completely.

Quality Guidelines Checklist:	**Level**	
1. For each child, transition plans are designed at least a year before each anticipated move from one educational environment to another	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
2. A Transition Planning Team has been formed and includes at least: a) the child's parents or guardian, b) the current teacher(s), c) a representative from the receiving environment(s), d) appropriate related services personnel, and e) a program administrator	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
3. Transition objectives are included in the child's IPP, with a timetable for implementation and review	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______

COMMUNITY-REFERENCED TRAINING

Description:

State Agencies maintain that there is a need for preschool children with handicaps to use acquired skills in home and community settings. The community in which skills are referenced and in which they are taught and demonstrated must be the child's local community. Family members must be involved in selecting community-referenced objectives and educational sites. Community-referenced instruction requires an examination of community settings to determine the individual child skill needs. For a skill to be considered learned, it must be demonstrated in environments in which it is typically used.

Quality Guidelines Checklist:	**Yes**	**No**
1. Is community-referenced training a goal of your program?	______	______
2. Do you have a written policy for this goal?	______	______
3. Do you provide staff training in this area?	______	______

For the next items, please use the following marking system

No progress = ______
Initiated = ______
Partially Implemented = ______
Implemented = ______

No progress: Nothing has been started in this area.
Initiated: Work has started, but only at the beginning level.
Partially Implemented: Efforts have been started, but have not been completed.
Implemented: This feature has been implemented completely.

Quality Guidelines Checklist:	**Level**	
1. IPP goals and objectives include performance in the home and in selected integrated community environments	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
2. A systematic process is used to facilitate family involvement in the selection of community-referenced objectives and the selection of the sites in which they will be taught	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
3. A systematic process is used to assist families to maintain educational skills in the home and community environments	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
4. Skills are taught and generalized within the child's local community on a regular basis	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______

FUNCTIONAL, LONGITUDINAL CURRICULAR EXPECTATIONS

Description:

State Agencies maintain that one of the goals of education should be to prepare preschool children for future school settings and their adult roles within society. In order to achieve this goal, curricular expectations must reflect demands of likely future environments. A functional curriculum will increase the number of age-appropriate, integrated current and future environments in which a child with handicaps can participate. Its use should begin at the preschool level, because instruction in important life skills must start far in advance of when they are needed.

Quality Guidelines Checklist:	**Yes**	**No**
1. Is the use of a functional curriculum a goal of your program?	______	______
2. Do you have a written policy for this goal?	______	______
3. Do you provide staff training in this area?	______	______

For the next items, please use the following marking system

No progress = ______
Initiated = ______
Partially Implemented = ______
Implemented = ______

No progress: Nothing has been started in this area.
Initiated: Work has started, but only at the beginning level.
Partially Implemented: Efforts have been started, but have not been completed.
Implemented: This feature has been implemented completely.

Quality Guidelines Checklist:	**Level**	
1. Age-appropriate, current and future environments for each child are examined to determine the activities and skills required to function in them	No progress Initiated Partially Implemented Implemented	______ ______ ______ ______
2. Conditions and criteria for goals and objectives in the IPP include performance in the home and in selected integrated community environments	No progress Initiated Partially Implemented Implemented	______ ______ ______ ______
3. IPP objectives met by the child increase the accessibility to age-appropriate environments	No progress Initiated Partially Implemented Implemented	______ ______ ______ ______
4. IPP objectives met by the child increase independent participation in age-appropriate environments	No progress Initiated Partially Implemented Implemented	______ ______ ______ ______

5. Settings, tasks, and materials used to teach, maintain, and generalize skills are selected to match those of age-appropriate environments	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
6. Child evaluations and assessments of present level of functioning are referenced to functional skills and activities	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
7. There is a policy and system that provides for extension of the school year to meet educational expectations for individual children	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
8. Written policy, procedures and IPP objectives demonstrate that behavioral excesses are viewed as educational needs, indicating areas where skills for more appropriate behavior need to be taught	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
9. Physical and environmental factors which may contribute to behavioral excesses are defined, observed and examined prior to implementing any behavior change program	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
10. Behavioral intervention programs emphasize increasing adaptive behavior, using positive consequences	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
11. Written policies and procedures specify that punishment, and other intrusive strategies of behavior intervention, are not used without review and written approval by program administrators and parents	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
12. Daily scheduled instructional activities include specific opportunities for children to make choices	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______

CLASSROOM MANAGEMENT

Description:

State Agencies agree that young children develop socially and intellectually through peer interactions in a supportive environment. All areas of children's development are integrated and grow in an atmosphere of warmth, personal respect, individuality, positive support, and responsiveness. Recognition of and respect for a child's uniqueness is essential. Interactions should encourage understanding and consideration of each child's handicapping condition. Because multiculturalism is the American norm, all interactions should encourage an understanding, and respect for, each child's ethnic heritage.

Quality Guidelines Checklist:	**Yes**	**No**
1. Is effective classroom management a goal of your program?	______	______
2. Do you have a written goal for this goal?	______	______
3. Do you provide staff training in this area?	______	______

For the next items, please use the following marking system

No progress = _____
Initiated = _____
Partially Implemented = _____
Implemented = _____

No progress: Nothing has been started in this area.
Initiated: Work has started, but only at the beginning level.
Partially Implemented: Efforts have been started, but have not been completed.
Implemented: This feature has been implemented completely.

Quality Guidelines Checklist:	**Level**	
1. Staff members interact frequently with all children and express respect and appropriately demonstrated affection toward all children by smiling, touching, holding, and speaking with them throughout the day at the children's eye level.	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
2. Staff members facilitate the development of self-esteem by expressing respect, acceptance, and comfort to children.	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
3. The staff is available and responsive to children and listens to them with attention and respect.	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______

4. The staff elicits communication from children using developmentally appropriate techniques.	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
5. The staff assists all children in being comfortable, relaxed, happy, and involved in play and other activities	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
6. The staff recognizes that young children learn from trial and error and they value mistakes as learning opportunities	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
7. The staff fosters cooperation and other prosocial behaviors among children	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
8. The staff's expectations of children's social behavior are developmentally appropriate	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
9. The staff uses positive guidance	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
10. Consistent, clear expectations are explained to children and understood by adults	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
11. The staff encourages developmentally appropriate independence and responsibility for self and others	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______

SYSTEMATIC DATA-BASED INSTRUCTION

Description:

State Agencies maintain that one of the educational goals for preschool children with handicaps is to have them respond to naturally occurring cues in their environments. If this goal is to be met, teachers must systematically plan instruction for acquisition, generalization, and maintenance of skills. Because many preschool children with handicaps learn at a slower rate as compared to their nonhandicapped peers, systematic data collection and analysis are necessary to determine the effectiveness of instruction and to identify the need for change. Preschool children with handicaps are often provided instruction by a variety of individuals other than the teacher. Therefore, each program must be written concisely and its implementation must be systematically managed and monitored.

Quality Guidelines Checklist:	**Yes**	**No**
1. Is systematic data-based instruction a goal of your program?	______	______
2. Do you have a written policy for this goal?	______	______
3. Do you provide staff training in this area?	______	______

For the next items, please use the following marking system

No progress = ______
Initiated = ______
Partially Implemented = ______
Implemented = ______

No progress: Nothing has been started in this area.
Initiated: Work has started, but only at the beginning level.
Partially Implemented: Efforts have been started, but have not been completed.
Implemented: This feature has been implemented completely.

Quality Guidelines Checklist:	**Level**	
1. A current schedule of daily activities describing what children are doing, when, and with whom is available	No progress Initiated Partially Implemented Implemented	______ ______ ______ ______
2. Instructional objectives included in the IPP are written with a) specified conditions, b) observable and measurable behavior, and c) criteria for generalization and maintenance	No progress Initiated Partially Implemented Implemented	______ ______ ______ ______
3. For each IPP objective being implemented, there is a written instructional plan in a format which allows for implementation by regular and substitute staff	No progress Initiated Partially Implemented Implemented	______ ______ ______ ______

4. Data reflecting child progress are collected and reviewed at least weekly on all current IPP objectives

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

5. At least 80% of each child's school day includes active participation in instructional activities directly related to IPP objectives

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

6. Educational IPP goals are met through child-initiated play based activities 50% of the time

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

7. Changes are made in IPP instructional programs based upon child progress data

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

8. Behavior intervention programs are stated with written plans, and child progress data are recorded daily

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

9. Instruction for each child occurs in a variety of groupings. This includes individual instruction, small and large group instruction, groups with children of similar needs, groups with children of different levels of handicapping conditions, and groups with nonhandicapped peers

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

10. There is regularly scheduled supervisory observation and feedback to staff regarding the reliability of program implementation, data collection, and its use

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

11. There is a systematic procedure that provides feedback, on at least a monthly basis, for planning the training and monitoring of paraprofessionals and volunteers implementing instructional programs

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

12. Evaluation includes direct observation of teaching staff resulting in goal setting and reobservation on a continuous cycle

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

EDUCATIONAL ENVIRONMENT

Description:

State agencies maintain that the educational environment affects the behavior and development of the child. The quality of the physical space, equipment and materials in all settings, affects the level of involvement of the children and the quality of interaction between adults and all children. A quality program must evaluate the amount, arrangement and use of its space and how these encourage growth and development through opportunities for exploration and learning.

Quality Guidelines Checklist:	**Yes**	**No**
1. Is the maintenance of a quality educational environment a goal of your program?	______	______
2. Do you have a written policy for this goal?	______	______
3. Do you provide staff training in this area?	______	______

For the next items, please use the following marking system

No progress = _____
Initiated = _____
Partially Implemented = _____
Implemented = _____

No progress: Nothing has been started in this area.
Initiated: Work has started, but only at the beginning level.
Partially Implemented: Efforts have been started, but have not been completed.
Implemented: This feature has been implemented completely.

Quality Guidelines Checklist:	**Level**	
1. Indoor and outdoor environments are safe, clean, attractive, and spacious	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
2. Furnishings are arranged to accommodate the physical needs of all children	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
3. Space is arranged to facilitate a variety of small group and/or individual activities	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
4. Equipment and activity centers are arranged to facilitate interaction and learning	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______

5. All areas are appropriate for the type of activity planned
    - No progress ______
    - Initiated ______
    - Partially Implemented ______
    - Implemented ______

6. All classroom materials are accessible, orderly, and in good repair
    - No progress ______
    - Initiated ______
    - Partially Implemented ______
    - Implemented ______

7. Space and fixtures are planned for all young children
    - No progress ______
    - Initiated ______
    - Partially Implemented ______
    - Implemented ______

SAFETY AND HEALTH

Description:

State agencies subscribe to the philosophy that in all educational settings it is necessary to provide a safe and healthy environment. No degree of planning or positive adult-child interactions can compensate for a dangerous environment. A quality early childhood program should prevent illness and accidents, be prepared to deal with emergencies, and educate children concerning safe and healthy practices.

Quality Guidelines Checklist:	**Yes**	**No**
1. Is the creation of a safe and healthy environment a goal of your program?	______	______
2. Do you have a written policy for this goal?	______	______
3. Do you provide staff training in this area?	______	______

For the next items, please use the following marking system

No progress = ______
Initiated = ______
Partially Implemented = ______
Implemented = ______

No progress: Nothing has been started in this area.
Initiated: Work has started, but only at the beginning level.
Partially Implemented: Efforts have been started, but have not been completed.
Implemented: This feature has been implemented completely.

Quality Guidelines Checklist:	**Level**	
1. All environments are in compliance with state fire, health, and safety laws and district regulations.	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
2. Adults are free of physical and psychological conditions which could adversely affect children's health	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
3. A written health file is maintained for each child which includes: complete health exam, record of immunizations, pertinent health history, and emergency contact number	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
4. The program has a written attendance policy which includes: parent notification guidelines, supervision of sick children, and protection of healthy children	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______

5. Staff are familiar with the child abuse reporting laws and district policies

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

6. Suspected child abuse and/or neglect is reported to appropriate authorities

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

7. Extra labeled clothing is kept on-hand for each child

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

8. All equipment which comes in contact with children is appropriately cleaned

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

9. Hand washing, toileting, and water fountain facilities are accessible to the classroom and have appropriate fixtures

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

10. Diaper changing areas have easy access to running water and are properly sanitized after each use.

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

11. Medication is stored and administered in accordance with state regulations

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

12. Food is properly stored and refrigerated

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

13. Snacks are planned to promote good nutritional habits

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

14. Trained staff are available at all times to deal with emergencies

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

15. Appropriate first aid supplies are readily available	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
16. Staff are aware of health and medical problems of each child	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
17. Facility has clearly marked emergency exits	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
18. Exits are accessible to nonambulatory and all other young children	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
19. Facility is barrier-free	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
20. Standard safety precautions have been taken	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
21. Procedures in case of fire are planned and practiced on a regular basis by children and staff	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
22. Emergency phone numbers are clearly posted by the phone	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______

HOME-SCHOOL PARTNERSHIP

Description:

State Agencies maintain that parents are significant participants in the development, implementation, and evaluation of their preschool children's instructional programs. While the nature and extent of parent involvement will vary from family to family, educators recognize the importance of the parents' role. All personnel involved with early intervention must establish and maintain ongoing communication with parents, provide information to assist families in gaining access to community resources, and share information through a mutually agreed-upon system of home-school communication.

Quality Guidelines Checklist:

	Yes	No
1. Is home-school partnership a goal of your program?	____	____
2. Do you have a written policy for this goal?	____	____
3. Do you provide staff training in this area?	____	____

For the next items, please use the following marking system

No progress = ____
Initiated = ____
Partially Implemented = ____
Implemented = ____

No progress: Nothing has been started in this area.
Initiated: Work has started, but only at the beginning level.
Partially Implemented: Efforts have been started, but have not been completed.
Implemented: This feature has been implemented completely.

Quality Guidelines Checklist:

	Level	
1. Parents are encouraged to visit the classroom and meet the teachers and school staff	No progress	____
	Initiated	____
	Partially Implemented	____
	Implemented	____
2. There is an established system for at least weekly parent and teacher communication	No progress	____
	Initiated	____
	Partially Implemented	____
	Implemented	____
3. There is an established system for providing parents with information about available community resources	No progress	____
	Initiated	____
	Partially Implemented	____
	Implemented	____
4. Families have the opportunity to participate in a parent interview or home and community environmental inventory process, to determine educational needs of high priority	No progress	____
	Initiated	____
	Partially Implemented	____
	Implemented	____

5. Children's IPPs and instructional programs, reflect specific input from parents	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
6. Parents are provided with written progress reports for their child	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
7. A personal file, accessible to all teachers is maintained for each child. Each file includes current a) medical records, b) adaptive equipment and therapy prescriptions, c) medical prescriptions and directions regarding administration of them, d) medical/safety precautions, and e) emergency medical procedures	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
8. There is an established system for informing and educating parents, of exemplary practices, rights, and responsibilities for services to children with handicaps	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______

PERSONNEL DEVELOPMENT

Description:

State Agencies maintain that all providers for preschool children with handicaps should employ the most qualified staff available. They should provide professional growth activities to ensure that staff develop skills necessary to meet children's educational needs. All educators, related service personnel, paraprofessionals and other appropriate personnel should receive ongoing inservice training relevant to preschool children with disabilities and in working as a team to meet children's educational needs. The program must provide supervision and staff development activities to promote quality intervention practices.

Quality Guidelines Checklist:	**Yes**	**No**
1. Is personnel development a goal of your program?	______	______
2. Do you have a written policy for this goal?	______	______
3. Do you provide personnel development and training activities?	______	______

For the next items, please use the following marking system

No progress = ______
Initiated = ______
Partially Implemented = ______
Implemented = ______

No progress: Nothing has been started in this area.
Initiated: Work has started, but only at the beginning level.
Partially Implemented: Efforts have been started, but have not been completed.
Implemented: This feature has been implemented completely.

Quality Guidelines Checklist:	**Level**	
1. All intervention personnel (i.e., administrators, teachers, related services, paraprofessionals) have training, and experience relevant to the children they serve	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
2. The district provides inservice training, at least annually, to all administrators, teachers, and other school staff regarding the needs of children with handicaps	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
3. Supervision of instructional staff includes a) using job descriptions describing duties specific to the assignment, b) supervisors who have training and experience relevant to quality educational practices for preschool children, c) systematic needs assessment, d) individualized training goals and activities, and e) at least quarterly observation and feedback	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______

4. Cooperation and collaboration among educators, and related service personnel are promoted through: a) special educators participate in professional activities with regular educators, b) planning time is provided for collaboration and team planning between educational personnel and related service providers

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

5. All personnel who work with individual children meet at least monthly to discuss progress and program changes

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

6. Paraprofessionals are provided with ongoing inservice training

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

7. Professional staff attend at least one regional or national professional conference yearly

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

8. Each instructional staff member attends at least four inservice training workshops yearly

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

9. At least yearly, the program uses an outside consultant, with recognized expertise, to provide technical assistance or training

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

10. The program maintains a collaborative research, development, and/or a training relationship with a community college, or university

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

11. The district provides funds for professional staff to complete at least one yearly course related to their instructional assignment

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

SYSTEMATIC EVALUATION OF EDUCATIONAL AND RELATED SERVICES

Description:

State Agencies maintain that educational programs for preschool children with handicaps need to be evaluated on a regular basis. The evaluation should also include indicators of program quality as listed in these guidelines. The evaluation should also address achievement of program goals; program effectiveness, including child progress; discrepancies needing remediation; directions for future program change; program impact upon preschool children with handicaps, their families, and the community; and program impact upon nonhandicapped preschool children. In addition to an annual internal review, there should also be periodic external evaluation of the program conducted by parents, a representative from another educational agency, and one or more professionals with knowledge and expertise relevant to current best educational practice for preschool children with handicaps.

Quality Guidelines Checklist:	**Yes**	**No**
1. Is systematic evaluation of educational and related services a goal of your program?	______	______
2. Do you have a written policy for this goal?	______	______

For the next items, please use the following marking system

No progress = ______
Initiated = ______
Partially Implemented = ______
Implemented = ______

No progress: Nothing has been started in this area.
Initiated: Work has started, but only at the beginning level.
Partially Implemented: Efforts have been started, but have not been completed.
Implemented: This feature has been implemented completely.

Quality Guidelines Checklist:	**Level**	
1. In addition to the IPP process and state compliance monitoring, there is a written plan and formal process for the annual review of the total intervention program	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
2. The annual review examines the extent to which goals and quality guidelines are achieved and the impact of educational and related services on children, their families, and community	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
3. The annual review examines the impact of educationally and socially integrated delivery of special education and related services on nonhandicapped children	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______

4. Provider staff, instructional staff, parents and early intervention local advisory group members are involved in the annual review	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
5. The written results of the annual review, noting strengths, weaknesses, and recommendations for change, are disseminated to parents, staff, and early intervention local advisory group members	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
6. There is a written plan and formal process established for conducting periodic outside evaluations of the annual review process by qualified professionals	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______

EDUCATIONAL/COMMUNITY FACILITIES

Description:

State agencies maintain that local facilities housing educational programs should provide equal access and involvement for preschool children with handicaps in age-appropriate settings. The school facility should not only be free of physical barriers but should create an environment that promotes integration and learning for all children.

Quality Guidelines Checklist:	**Yes**	**No**
1. Is the establishment of barrier-free facilities a goal of your program?	______	______
2. Do you have a written policy for this goal?	______	______
3. Are the facilities inspected on a regular basis for compliance to this goal?	______	______

For the next items, please use the following marking system

No progress = _____
Initiated = _____
Partially Implemented = _____
Implemented = _____

No progress: Nothing has been started in this area.
Initiated: Work has started, but only at the beginning level.
Partially Implemented: Efforts have been started, but have not been completed.
Implemented: This feature has been implemented completely.

Quality Guidelines Checklist:	**Level**	
1. Children have access to and use all age-appropriate school facilities (including hallways, entrances and exits, classrooms, cafeteria, gymnasium, sports equipment and music equipment.	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
2. All classroom sites are determined on the basis of age-appropriateness and availability of community resources.	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
3. All classroom sites have the following characteristics: a) age-appropriate decor, b) adequate space for individual and group instruction and needed special equipment, and c) appropriate lighting and acoustics.	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______
4. Facilities have the necessary adaptive equipment and space for personal care, mobility, and age-appropriate leisure and play, activities.	No progress	______
	Initiated	______
	Partially Implemented	______
	Implemented	______

5. Restroom and personal care facilities are safe and provide privacy for children and staff.

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

6. Facilities are equipped for emergency situations: a) the classroom connects to office by phone/intercom, b) exits are easily accessible for all students and staff, c) safety and emergency plans are developed and followed, and d) fire drills are held on a regular basis.

No progress ______
Initiated ______
Partially Implemented ______
Implemented ______

APPENDIX 2

Overview of EPS

Evaluation and Programming System: For Infants and Young Children (EPS)

Overview of Critical Information

	EPS-I	EPS-II
Purpose:	Provide information to develop IEPs/IFSPs and monitor child progress	Provide information to develop IEPs/IFSPs and monitor child progress
Type of Tool:	Criterion-referenced, curriculum-based assessment/evaluation tool	Criterion-referenced curriculum-based assessment/evaluation tool
CA Range:	1 month to 6 years	3 to 8 years
DA Range:	1 month to 3 years	3 to 6 years
Test Domain:	Social-communication, social, self-care, cognitive, gross motor, fine motor	Social-communication, social, self-care, cognitive, gross motor, fine motor
Users:	Interventionists, allied health professionals	Interventionists, allied health professionals
Administration Time:	Variable from 1 to 4 hours	Variable from 1 to 4 hours
Associated IEP Goals:	Yes	Yes
Associated Data Collection Forms:	Yes	Yes
Associated Parent Forms:	Yes	Yes

Information from Diane Bricker, Center on Human Development, University of Oregon, Eugene, OR.

APPENDIX 3

Environmental Survey

ENVIRONMENTAL SURVEY

Setting: Dairy Queen for family lunch.

Student(s): Jon Smith

Parent/Teacher/Supervisor: Mr. and Mrs. Smith

Skill Area	Priority Skill	Where and Why Each Skill is Important
Communication - expressive - receptive	Uses gestures and single words.	Indicates preference for lunch.
Independent Living - mobility - dressing - eating - hygiene	Drinks from a straw.	
Social - interactional - leisure skills - behaviors	Waits his turn.	Stands in line at counter with his family until it is his time to order.
Motor - fine motor - pre-vocational - gross motor - physical education		
Academic - math - time concepts - money concepts - reading - writing	Pays for his own lunch.	Hands money to the cashier with assistance.

STUDENT: ______________________________
AGE: ______________________________

Form 4 (Kindergarten)
ROUTINES CHECKLIST:
GENERAL COMMUNITY

Indicate the student's level of performance on age-appropriate routines in this domain. Also indicate the related skills that the student performs with adequate quality for his/her age. Note priorities for the student's next IEP. Add routines the student participates in that are not listed here.

		Performance Level?			Adequate Performance Quality?						
		X one			X all that apply						
GOAL AREAS	AGE-APPROPRIATE ACTIVITIES	Assistance on most steps	Assistance on some steps	Independent	Initiates?	Finishes/ends?	Problem solves?	Communicates?	Social skills?	Makes choices?	NOTE PRIORITY GOAL AREAS, PRIORITY ACTIVITIES, AND PRIORITY SKILLS TO BE ACQUIRED.
TRAVEL	Walking (wheeling) to/from										
	destination										
	Riding city bus/										
	wheelchair van										
	Riding in a car										
	Using caution with										
	strangers/										
	problem solving										
	when lost										
	Riding a bike										
GENERAL SHOPPING	Buying toys and games										
GROCERY SHOPPING	Buying a snack										
RESTAURANT USE	Eating out in a										
	restaurant (fast										
	food, sit down,										
	cafeteria)										

PROJECT EN TRANS
Transition Skills Assessment I

Child's Name ______________________________ **Date** ____________________

School ______________________________ **Recorder** ____________________

Type Classroom ______________________________

	No	Incon-sistent	Yes	Comments
CLASSROOM RULES 1. Follows established class rules.				
2. Moves through routine transitions smoothly.				
3. Walks rather than runs when indoors.				
4. Controls voice in classroom.				
5. Can "line-up" and stay in line.				
6. Raises hand and/or gets teacher's attention when necessary.				
7. Waits appropriately for teacher response to signal (raised hand).				
8. Helps with clean-up of a group activity when given a direction by an adult to assist with clean-up.				
9. Replaces materials and "cleans-up" own workspace.				
10. Stays in "own space" for activity.				
WORKSKILLS 1. Refrains from disturbing or disrupting the activities of others.				
2. Displays appropriate levels of independence, e.g., does not need excessive amounts of supervision to complete simple tasks.				
3. Produces work of acceptable quality given her/his skill level.				
4. Asks questions to get information about assigned tasks when did not understand initial instructions.				
5. Follows a three part direction related to task.				
6. Works independently on a developmentally appropriate activity assigned by an adult.				
7. Finds materials needed for task.				
8. Selects and works on a table activity independently.				
9. Recognizes completion of a task, indicates to adult that he/she is finished and stops activity.				
10. Works on assigned task for 15 minutes.				
11. Self-corrects errors.				
12. Recalls and completes task demonstrated previously.				
13. Uses classroom equipment independently, e.g., pencil sharpener, language master.				
14. Uses crayons and scissors appropriately without being destructive.				
SELF-MANAGEMENT 1. Monitors appearance, e.g., keeps nose clean, adjusts clothing, uses napkin.				
2. Locates and uses a public restroom with minimal assistance in the school, a store, or a restaurant.				
3. Comes to an adult, when called or signaled by a bell or whistle, and lines up.				
4. Will put on/take off outer clothing within a reasonable amount of time.				
5. Eats lunch or snack with minimal assistance.				
6. Comes into the classroom or house independently from the bus or car.				
7. Goes from classroom to bus or car independently.				

APPENDIX 4

Blank Forms

TEACHING RESEARCH EARLY CHILDHOOD PROGRAMS
RAW PROGRAM DATA SHEET

Date	Reinforcer	Phase/ Step	Trials										Comments

Activity Matrix

Name ____________________

		IFSP Objectives						
Activity	Time							

Teaching Research Models, Monmouth, OR

F5-7blnk

TEACHING RESEARCH INTEGRATED PRESCHOOL MODEL
DISTRIBUTED TRIAL DATA SHEET

CHILD: ______________________________ DATE: ______________

Skill	Phase/ Step Description	Phase Step	Large Group	Snack	Gross Motor	Library	SMALL GROUPS				
							Art	House Corner	Blocks	Table Toys	Sand & Water

LIMITED ENVIRONMENT PROGRAMS:

COMMENTS:

TEACHING RESEARCH INTEGRATED PRESCHOOL MODEL
DATA SUMMARY SHEET

Name ______________________________

Skill/Criterion	Date																				

Phase/Step																				
# Correct/Total																				
% Correct																				

Phase/Step																				
# Correct/Total																				
% Correct																				

Phase/Step																				
# Correct/Total																				
% Correct																				

Phase/Step																				
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Phase/Step																				
# Correct/Total																				
% Correct																				

Phase/Step																				
# Correct/Total																				
% Correct																				

TEACHING RESEARCH INTEGRATED PRESCHOOL MODEL
PROGRAM COVER AND TESTING PROCEDURES DATA SHEET

Child's Name: ______________________________ Program: ______________

Cues:

Materials:

Reinforcement Procedure:

Correction Procedure:

Criterion: ____________________ Date: __________

____________________ __________

____________________ __________

Date	Testing Procedure	Phase/Step	Trials										Comments

BEHAVIOR TREATMENT DATA FORM

Name ____________________ Date Recording Initiated: ____________ Date Recording Terminated: ____________

Behaviors								Total	Summary

F6-2

TEACHING RESEARCH INTEGRATED PRESCHOOL BEHAVIOR PROGRAM COVER SHEET

Name ______________________ Date Initiated: __________ Date Terminated: __________

Program to be Conducted: Home __________ School __________ Both __________

BASELINE DATA

Baseline Collection Procedure: ______________________________

Date	Data	Comments and Treatment

Program Objective: ______________________________

SYNOPSIS OF PROGRAM

Date	Weekly Total	Treatment Number

Date	Weekly Total	Treatment Number

F6-3

BEHAVIOR PROGRAM TREATMENT FORM

Name ______________________________ Date: ______________

BEHAVIOR TO INCREASE: ______________ BEHAVIOR TO DECREASE: ______________

Treatment Number	When BEHAVIOR TO INCREASE occurs, do this:	When BEHAVIOR TO DECREASE occurs, do this:

F6-4

TEACHING RESEARCH EARLY CHILDHOOD PROGRAMS
GROUP OBSERVATION FORM

Trainee: ____________ Observer: ____________ Setting: ____________ Date: ________ Time: ______

Actively supervises and rotates attention		Interactions		CUE/DIRECTIVE					CONSEQUENCES										
		Indirect language stimulation, explanations, etc.			Inappropriate				+ Reinforcers					Correction					
Yes	No	+	-	Appropriate	Weak	Repeat	Negative	No cue	Appropriate	No reinforc'r	Weak	Delayed	Inappropriate	Appropriate	Inappropriate	No	Cue	Help	Reinforce
TARGET SKILLS		Data Recorded																	
		Yes	No																

INTERACTIONS:	CUES/DIRECTIVES	CONSEQUENCES	RATIO + / -
___/___ = ____%	___/___ = ____%	___/___ = ____%	_____/___ ___

FEEDBACK

Positive Feedback	Recommendations for Improvement
1.	1.
2.	2.
3.	3.
4.	

F7-5blk

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